WSR 09-20-046
PROPOSED RULES
DEPARTMENT OF LICENSING
[Filed September 30, 2009, 3:50 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 09-09-106.

Title of Rule and Other Identifying Information: Add new section WAC 308-408B-130 Fundamentals supplemental course.

Washington state applicants not seeking reciprocity who lack the required one hundred twenty hours of home inspection classroom education, but have completed a minimum of eighty hours of department approved classroom instruction can apply to the department for consideration of an approved supplemental course.

The applicant must provide a copy of their certificate(s) of completion, course outline that includes hours spent on each topic, and proof of testing. The supplemental course and the applicant's previous classroom instruction must meet or exceed the current board approved fundamentals curriculum.

Applicants who have taken home inspection courses must provide proof that they had successfully completed the course not earlier than June 12, 2006.

This rule is effective until June 1, 2010.

Hearing Location(s): 2000 4th Avenue West, 2nd Floor Conference Room, Olympia, WA 98507, on November 11, 2009, at 10:00 a.m.

Date of Intended Adoption: November 16, 2009.

Submit Written Comments to: Rhonda Myers, 2000 4th Avenue West, 2nd Floor Conference Room, e-mail rmyers@dol.wa.gov, fax (360) 586-0998, by November 2, 2009.

Assistance for Persons with Disabilities: Contact Gale Mitchell, by November 2, 2009, TTY (360) 664-8885 or (360) 664-6487.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: This proposal will create a supplemental course for applicants without enough education to reach the required one hundred and twenty hours of classroom training in the board approved fundamentals.

Reasons Supporting Proposal: This will allow the creation of a supplemental course for applications [applicants who] have taken home inspector courses prior to the enactment of RCW 18.18.280. This will help them to attain the required one hundred and twenty hours of classroom fundamentals.

Statutory Authority for Adoption: RCW 18.280.050(1).

Statute Being Implemented: RCW 18.280.060(1).

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

Name of Proponent: Department of licensing, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation and Enforcement: Rhonda Myers and Jerry McDonald, 2000 4th Avenue West, (360) 664-6487.

No small business economic impact statement has been prepared under chapter 19.85 RCW. Rule is for individual licensees and not small business enterprises.

A cost-benefit analysis is not required under RCW 34.05.328. The department of licensing is not one of the named agencies under this RCW.

September 30, 2009
Walt Fahrer
Rules Coordinator

Chapter 308-408B WAC

EDUCATION—HOME INSPECTOR COURSE APPROVAL

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules. The rule published above varies from its predecessor in certain respects not indicated by the use of these markings.

NEW SECTION

WAC 308-408B-130 Fundamentals supplemental course. Washington state applicants not seeking reciprocity who lack the required one hundred twenty hours of home inspection classroom education, but have completed a minimum of eighty hours of department approved classroom instruction can apply to the department for consideration of an approved supplemental course.

The applicant must provide a copy of their certificate(s) of completion, course outline that includes hours spent on each topic, and proof of testing. The supplemental course and the applicant's previous classroom instruction must meet or exceed the current board approved fundamentals curriculum.

Applicants who have taken home inspection courses must provide proof that they had successfully completed the course not earlier than June 12, 2006.

This rule is effective until June 1, 2010.

WSR 09-20-056
PROPOSED RULES
HEALTH CARE AUTHORITY
(Public Employees Benefits Board)
[Order 09-02—Filed October 2, 2009, 9:28 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 09-10-053.

Title of Rule and Other Identifying Information: Public employee's benefits board (PEBB) rules related to enrollment in chapter 182-08 WAC; eligibility in chapter 182-12 WAC; and appeals in chapter 182-16 WAC.

Hearing Location(s): Health Care Authority, 676 Woodland Square Loop S.E., The Sue Crystal Center, Olympia, WA, on November 10, 2009, at 2:30 p.m.

Date of Intended Adoption: November 17, 2009.

Submit Written Comments to: Matthew Albright, 676 Woodland Square Loop S.E., P.O. Box 42684, Olympia, WA 98504-2684, e-mail Matthew.Albright@hca.wa.gov, fax (360) 923-2602, by November 10, 2009.

Assistance for Persons with Disabilities: Contact Nikki Johnson by November 3, 2009, TTY (888) 923-5622 or (360) 923-2805.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The main purpose of this rule making is to amend PEBB rules in Title 182 WAC and adopt new rules to:

1. Implement provisions of ESHB 2245 affecting employee eligibility.

2. Implement PEBB policy clarifying dependent eligibility and enrollment requirements.

3. Amend rules to align with federal laws, including Michelle's Law and the various economic stimulus bills.

4. Implement state legislation.

5. Allow members sufficient time following the birth or adoption of a child to provide information necessary for health care authority (HCA) to provide health care coverage to newborn and newly adopted children back to the date of birth.

6. Define eligibility criteria for domestic partners.

7. Clarify language regarding special open enrollment events.

8. Clarify options for continuing coverage for employees when they are no longer eligible for PEBB insurance coverage paid for by their employer.

In addition to these specific subject areas, HCA will conduct a full review of PEBB rules in these chapters, make necessary technical corrections, and make necessary amendments that effectuate legislative action and PEBB policy.

Statutory Authority for Adoption: Chapter 41.05 RCW.

Statute Being Implemented: Chapter 537, Laws of 2009.

Rule is necessary because of federal law, Public Law 110-381 (Michelle's Law).

Name of Proponent: Washington state health care authority, governmental.

Name of Agency Personnel Responsible for Drafting: Matthew Albright, 676 Woodland Square Loop, Lacey, WA, (360) 923-2629; Implementation: Barbara Scott, 676 Woodland Square Loop, Lacey, WA, (360) 923-2642; and Enforcement: Mary Fliss, 676 Woodland Square Loop, Lacey, WA, (360) 923-2640.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The joint administrative rules review committee has not requested the filing of a small business economic impact statement, and there will be no costs to small businesses.

A cost-benefit analysis is not required under RCW 34.05.328. RCW 34.05.328 does not apply to the health care authority rules unless requested by the joint administrative rules [review] committee or applied voluntarily.

October 2, 2009
Jason Siems
Rules Coordinator

AMENDATORY SECTION (Amending Order 08-03, filed 10/1/08, effective 1/1/09)

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.

"Agency" means the health care authority.

"Benefits eligible position" means any position held by an employee who is eligible for benefits under WAC 182-12-114, with the exception of employees who establish eligibility under WAC 182-12-114 (2) or (3)(a)(ii).

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

"Comprehensive employer sponsored medical" includes insurance coverage continued by the employee or their dependent under COBRA. It does not include an employer's retiree coverage, with the exception of a federal retiree plan.

"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 medical insurance by a retiree or eligible survivor.

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

"Dependent care assistance program" or "DCAP" means a benefit plan whereby state and public employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan authorized in chapter 41.05 RCW.

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

"Employer group" means those employee organizations representing state civil service employees, ((~~blind vendors,~~)) counties, municipalities, political subdivisions, ((~~and~~)) tribal governments, school districts, and educational service districts participating in PEBB insurance coverage under contractual agreement as described in WAC 182-08-230.

"Employing agency" means a division, department, or separate agency of state government, including an institution of higher education; a county, municipality, school district, educational service district, or other political subdivision; or a tribal government covered by chapter 41.05 RCW.

"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.

"Faculty" means an academic employee of an institution of higher education whose workload is not defined by work hours but whose appointment, workload, and duties directly serve the institution's academic mission; as determined under the authority of its enabling statutes, its governing body, and any applicable collective bargaining agreement.

"Health plan" or "plan" means a medical or dental plan developed by the public employees benefits board and provided by a contracted vendor or self-insured plans administered by the HCA.

"Institutions of higher education" means the state public research universities, the public regional universities, The Evergreen State College, the community and technical colleges, and includes the higher education personnel board and the state board for community and technical colleges.

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

"Layoff" means a change in employment status due to an employer's lack of funds or an employer's organizational change.

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

"Life insurance" includes basic life insurance paid for by the ((~~employer~~)) employing agency, life insurance offered to employees on an optional basis, and retiree life insurance.

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby state and public employees may reduce their salary before taxes to pay for medical expenses not reimbursed by insurance as provided in the salary reduction plan authorized in chapter 41.05 RCW.

"Open enrollment" means a time period when: Subscribers may apply to transfer their enrollment from one health plan to another; a dependent may be enrolled; a ((~~dependent's enrollment~~)) dependent may be ((~~waived~~)) removed from coverage; or an employee who previously waived medical may enroll in medical. Open enrollment is also the time when employees may enroll in or change their election under the DCAP, the medical FSA, or the premium payment plan. An "annual" open enrollment, designated by the administrator, is an open enrollment when all PEBB subscribers may make enrollment changes for the upcoming year. A "special" open enrollment is triggered by a specific life event. For special open enrollment events as they relate to specific PEBB benefits, see WAC 182-08-198, 182-08-199, 182-12-128, 182-12-262.

"PEBB" means the public employees benefits board.

"PEBB appeals committee" means the committee that considers appeals relating to the administration of PEBB benefits by the PEBB ((~~benefits services~~)) program. The administrator has delegated the authority to hear appeals at the level below an administrative hearing to the PEBB appeals committee.

"PEBB benefits" means one or more insurance coverage or other employee benefit administered by the PEBB ((~~benefits services~~)) program within the HCA.

"PEBB ((~~benefits services~~)) program" means the program within the ((~~health care authority~~)) HCA which administers insurance and other benefits for eligible employees of the state (as defined in WAC ((~~182-12-115~~)) 182-12-114), eligible retired and disabled employees of the state (as defined in WAC 182-12-171), eligible dependents (as defined in WAC 182-12-250 and 182-12-260) and others as defined in RCW 41.05.011.

"Premium payment plan" means a benefit plan whereby state and public employees may pay their share of group health plan premiums with pretax dollars as provided in the salary reduction plan.

"Salary reduction plan" means a benefit plan whereby state and public employees may agree to a reduction of salary on a pretax basis to participate in the DCAP, medical FSA, or premium payment plan as authorized in chapter 41.05 RCW.

"Seasonal employee" means an employee hired to work during a recurring, annual season with a duration of three months or more, and anticipated to return each season to perform similar work.

"State agency" means an office, department, board, commission, institution, or other separate unit or division, however designated, of the state government and all personnel thereof. It includes the legislature, executive branch, and agencies or courts within the judicial branch, as well as institutions of higher education and any unit of state government established by law.

"Subscriber" ((~~or "insured"~~)) means the employee, retiree, COBRA beneficiary or eligible survivor who has been designated by the HCA as the individual to whom the HCA and contracted vendors will issue all notices, information, requests and premium bills on behalf of enrollees.

"Termination of the employment relationship" means that an employee resigns or an employee is terminated and the employing agency has no anticipation that the employee will be rehired.

"Tribal government" means an Indian tribal government as defined in Section 3(32) of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, or an agency or instrumentality of the tribal government, that has government offices principally located in this state.

"Waive" means to interrupt an eligible employee's enrollment ((~~or postpone enrollment~~)) in a PEBB health plan ((~~by an~~)) because the employee (((~~as defined in WAC 182-12-115) or a dependent who meets eligibility requirements in WAC 182-12-260~~)) is enrolled in other comprehensive group coverage or is on approved educational leave (see WAC 182-12-128 and 182-12-136).

AMENDATORY SECTION (Amending Order 07-01, filed 10/3/07, effective 11/3/07)

WAC 182-08-120 Employer contribution. The employers' contribution must be used to provide insurance coverage for the basic life insurance benefit, ((~~a~~)) the basic long-term disability benefit, medical, and dental, and to establish a reserve for any remaining balance. There is no employer contribution available for any other insurance coverage for employees employed by state agencies.

AMENDATORY SECTION (Amending Order 08-03, filed 10/1/08, effective 1/1/09)

WAC 182-08-180 Premium payments and refunds. PEBB premiums ((~~payments~~)) for retiree, COBRA or ((~~an extension of~~)) PEBB ((~~insurance~~)) continuation coverage begin to accrue the first of the month of PEBB insurance coverage.

Premium is due for the entire month of insurance coverage and will not be prorated during the month of death or loss of eligibility of the enrollee except when eligible for life insurance conversion.

PEBB premiums will be refunded using the following method:

(1) When ((~~a~~)) any PEBB subscriber submits an enrollment change affecting eligibility, such as for example: Death, divorce, or when no longer ((~~a~~)) an eligible dependent

as defined at WAC 182-12-260 no more than three months of accounting adjustments and any excess premium paid will be refunded to any individual or employing agency except as indicated in WAC 182-12-148((~~(3)~~)) (4).

(2) Notwithstanding subsection (1) of this section, the PEBB assistant administrator or the PEBB appeals committee may approve a refund which does not exceed twelve months of premium if both of the following occur:

(a) The PEBB subscriber or a dependent or beneficiary of a subscriber submits a written appeal to the PEBB appeals committee; and

(b) Proof is provided that extraordinary circumstances beyond the control of the subscriber, dependent or beneficiary made it virtually impossible to submit the necessary information to accomplish an enrollment change within sixty days after the event that created a change of premium.

(3) Errors resulting in an underpayment to HCA must be reimbursed by the ((~~employer~~)) employing agency or subscriber to the HCA. Upon request of an ((~~employer~~)) employing agency, subscriber, or beneficiary, as appropriate, the HCA will develop a repayment plan designed not to create undue hardship on the ((~~employer~~)) employing agency or subscriber.

(4) HCA errors will be adjusted by returning the excess premium paid, if any, to the employing agency, subscriber, or beneficiary, as appropriate.

AMENDATORY SECTION (Amending Order 08-03, filed 10/1/08, effective 1/1/09)

WAC 182-08-190 The employer contribution is set by the HCA and paid to the HCA for all eligible employees. ((~~Every department, division, or agency of state government, and such county, municipal or other political subdivision, tribal government, or an agency or instrumentality of a tribal government, K-12 school district or educational service district that are covered under PEBB insurance coverage,~~)) State agencies and employer groups that participate in the PEBB program under contract with the HCA must pay premium contributions to the HCA for insurance coverage for all eligible employees and their dependents.

(1) Employer contributions ((~~are~~)) for state agencies set by the HCA ((~~and~~)) are subject to the approval of the governor for availability of funds as specifically appropriated by the legislature for that purpose. Insurance and health care contributions for ferry employees shall be governed by RCW 47.64.270.

(2) Employer contributions must include an amount determined by the HCA to pay administrative costs to administer insurance coverage for employees of these groups.

(3) Each ((~~eligible~~)) employee ((~~in pay status eight or more hours during a calendar month~~)) of a state agency eligible under WAC 182-12-131 or each eligible employee of a state agency on leave under the federal Family and Medical Leave Act (FMLA) is eligible for the employer contribution. The entire employer contribution is due and payable to HCA even if medical is waived.

(4) ((~~PEBB insurance coverage for any county, municipality or other political subdivision, tribal government, or an agency or instrumentality of a tribal government, or any K-12 school district or educational service district may be canceled by HCA if the premium contributions are delinquent more than ninety days~~)) Employees of employer groups eligible under criteria stipulated under contract with the HCA are eligible for the employer contribution. The entire employer contribution is due and payable to the HCA even if medical is waived.

(5) Washington state patrol officers disabled while performing their duties as determined by the chief of the Washington state patrol are eligible for the employer contribution for PEBB benefits as authorized in RCW 43.43.040. No other retiree or disabled employee is eligible for the employer contribution for PEBB benefits unless they are an eligible employee as defined in WAC ((~~182-12-115~~)) 182-12-114 or 182-12-131.

(6) The terms of payment to HCA for employer groups shall be stipulated under contract with the HCA.

AMENDATORY SECTION (Amending Order 08-03, filed 10/1/08, effective 1/1/09)

WAC 182-08-196 What happens if my health plan becomes unavailable? Employees ((~~and~~)), retirees and survivors, and enrollees in PEBB continuation coverage for whom the chosen health plan becomes unavailable due to a change in contracting service area((~~,~~)) or the retiree's entitlement to medicare must select a new health plan within sixty days after notification by the PEBB ((~~benefits services~~)) program.

(1) Employees who fail to select a new medical or dental plan within the prescribed time period will be enrolled in a successor plan if one is available or will be enrolled in the Uniform Medical Plan ((~~Preferred Provider Organization or~~)), the Uniform Dental Plan, or a plan selected by the administrator, along with the employee's existing dependent enrollment.

(2) Retirees and survivors eligible under WAC 182-12-250 or 182-12-265 who fail to select a new health plan within the prescribed time period will be enrolled in a successor plan if one is available or will be enrolled in the Uniform Medical Plan ((~~Preferred Provider Organization~~)), and the Uniform Dental Plan((~~. However, retirees enrolled in medicare Parts A and B, and who enroll in medicare Part D may be assigned to a PEBB medicare plan that does not include a pharmacy benefit~~)), or a plan selected by the administrator.

Any subscriber assigned to a health plan as described in this rule may not change health plans until the next open enrollment except as allowed in WAC 182-08-198.

(3) Enrollees ((~~continuing~~)) in PEBB ((~~health plan enrollment~~)) continuation coverage under WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, or 182-12-270(2) must select a new health plan no later than sixty days after notification by the PEBB ((~~benefits services~~)) program ((~~or their~~)). If enrollees fail to select a new health plan ((~~enrollment~~)) within sixty days of the notification, health plan coverage will end as of the last day of the month in which the plan is no longer available.

AMENDATORY SECTION (Amending Order 08-03, filed 10/1/08, effective 1/1/09)

WAC 182-08-197 When must newly eligible employees ((must)) select PEBB benefits and complete enrollment forms ((within thirty-one days of the date they become eligible for PEBB benefits.))? (1) Employees who are newly eligible for PEBB benefits must complete the appropriate forms indicating enrollment and their health plan choice, or their decision to waive medical under WAC 182-12-128. Employees must return the forms to their employing agency no later than thirty-one days after they become eligible for PEBB benefits((, as stated in)) under WAC ((182-12-115)) 182-12-114. Newly eligible employees who do not return an enrollment form to their employing agency indicating their medical and dental choice within thirty-one days will be enrolled in a health plan as follows:

(a) Medical enrollment will be Uniform Medical Plan ((Preferred Provider Organization)); and

(b) Dental enrollment (if the ((employing agency)) employer group participates in PEBB dental) will be Uniform Dental Plan.

(2) Employees who are newly eligible ((employees)) may enroll in optional insurance coverage (except for employees of ((agencies)) employer groups that do not participate in life insurance or long-term disability insurance).

(a) To enroll in the amounts of optional life insurance available without health underwriting, employees must return a completed life insurance enrollment form to their employing agency no later than sixty days after becoming eligible for PEBB benefits.

(b) To enroll in optional long-term disability insurance without health underwriting, employees must return a completed long-term disability enrollment form to their employing agency no later than thirty-one days after becoming eligible for PEBB benefits.

(c) To enroll in long-term care insurance with limited health underwriting, employees must return a completed long-term care enrollment form to the contracted vendor no later than thirty-one days after becoming eligible for PEBB benefits.

(d) Employees may apply for optional life, long-term disability, and long-term care insurance at any time by providing evidence of insurability and receiving approval from the contracted vendor.

(3) Employees who are eligible to participate in the state's salary reduction plan (see WAC 182-12-116) will be automatically enrolled in the premium payment plan upon enrollment in medical so employee medical premiums are taken on a pretax basis. To opt out of the premium payment plan, new employees must complete the appropriate form and return it to their employing agency no later than thirty-one days after they become eligible for PEBB benefits.

(4) Employees who are eligible to participate in the state's salary reduction plan may enroll in the state's medical FSA or DCAP or both. To enroll in these optional PEBB benefits, employees must return the appropriate enrollment forms to their employing agency or PEBB designee no later than thirty-one days after becoming eligible for PEBB benefits.

(5) ((When an employee's employment ends,)) The employer contribution toward insurance coverage ends ((()))according to WAC 182-12-131((.)). Employees who ((are later reemployed and)) become newly eligible for ((PEBB benefits)) the employer contribution enroll as described in subsections (1) and (2) of this section, with the following exceptions in which insurance coverage elections stay the same:

(a) When an employee transfers from one employing agency to another employing agency without a break in state service. This includes movement of employees between any ((agencies)) entities described ((as eligible groups)) in WAC 182-12-111 and participating in PEBB benefits.

(b) When employees have a break in state service that does not interrupt their employer contribution((-based enrollment in)) toward PEBB insurance coverage.

(c) When employees continue insurance coverage by self-paying the full premium under WAC 182-12-133 (1) or (((2))) 182-12-142 and ((are reemployed into a benefits eligible position)) become newly eligible for the employer contribution before the end of the maximum number of months allowed for continuing PEBB health plan enrollment under those rules. Employees who are eligible to continue optional life or optional long-term disability under continuation coverage but discontinue that insurance coverage are subject to the insurance underwriting requirements if they apply for the insurance when they return to ((employment)) work or become eligible again for the employer contribution.

(6) When an employee's employment ends, participation in the state's salary reduction plan ends. If the employee is hired into a new position that is eligible for PEBB benefits in the same year, the employee may not resume participation in DCAP or medical FSA until the beginning of the next plan year, unless the time between employments is less than thirty days.

AMENDATORY SECTION (Amending Order 08-03, filed 10/1/08, effective 1/1/09)

WAC 182-08-198 When may a subscriber change health plans? Subscribers may change health plans at the following times:

(1) **During annual open enrollment:** Subscribers may change health plans during the annual open enrollment. The subscriber must submit the appropriate enrollment forms to change health plan no later than the end of the annual open enrollment. Enrollment in the new health plan will begin January 1st of the following year.

(2) **During a special open enrollment:** Subscribers may change health plans outside of the annual open enrollment if a special open enrollment event occurs. The change in enrollment must be allowable under Internal Revenue Code (IRC) and correspond to the event that creates the special open enrollment for either the subscriber or the subscriber's dependents or both. To make a health plan change, the subscriber must submit the appropriate enrollment forms (and a completed disenrollment form, if required) no later than sixty days after the event occurs. Employees submit the enrollment forms to their employing agency. All other subscribers, including retirees, COBRA, and other self-pay subscribers,

submit the enrollment forms to the PEBB ((~~benefits services~~)) program. ((~~Enrollment~~)) Insurance coverage in the new health plan will begin the first day of the month following the event that created the special open enrollment; or in cases where the event occurs on the first day of the month, ((~~enrollment~~)) insurance coverage will begin on that date. If the special open enrollment is due to the birth ((~~or~~)), adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, ((~~enrollment~~)) insurance coverage will begin the month in which the event occurs. The following events create a special open enrollment:

(a) Subscriber acquires a new eligible dependent through marriage, registering a domestic partnership with Washington state, birth, adoption or ((~~placement for adoption~~)) when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption, legal custody or legal guardianship;

(b) Subscriber's dependent child becomes eligible by fulfilling PEBB dependent eligibility criteria;

(c) Subscriber loses an eligible dependent or a dependent no longer meets PEBB eligibility criteria;

(d) Subscriber has a change in marital status or Washington state registered domestic partnership status, including legal separation documented by a court order;

(e) Subscriber or a dependent loses comprehensive group health coverage;

(f) Subscriber or a dependent has a change in employment status that affects the subscriber's or a dependent's eligibility, level of benefits, or cost of insurance coverage((~~.~~));

(g) Subscriber or a dependent has a change in residence that affects health plan availability, benefits, or cost of insurance coverage. If the subscriber moves and the subscriber's current health plan is not available in the new location but the subscriber does not select a new health plan, the PEBB ((~~benefits services~~)) program may enroll the subscriber in the Uniform Medical Plan ((~~Preferred Provider Organization~~)) or Uniform Dental Plan((~~.~~));

(h) Subscriber receives a court order or medical support order requiring the subscriber, the subscriber's spouse, or the subscriber's ((~~qualified~~)) Washington state registered domestic partner to provide insurance coverage for an eligible dependent((~~.~~));

(i) Subscriber ((~~receives formal notice that~~)) or a dependent becomes eligible for a medical assistance program under the department of social and health services ((~~has determined it is more cost-effective to enroll the eligible subscriber or eligible dependent in PEBB medical than~~)), including medicaid or the children's health insurance program (CHIP), or the subscriber or a dependent loses eligibility in such a medical assistance program((~~.~~));

(j) A dependent dies;

(k) Seasonal employees whose off-season occurs during the annual open enrollment. They may select a new health plan upon their return to work((~~.~~));

((~~(k) Subscriber enrolls in PEBB retiree insurance coverage.~~))

(l) Subscriber or an eligible dependent becomes entitled to medicare, enrolls in or disenrolls from a medicare Part D plan((~~.~~));

(m) Subscriber experiences a disruption that could function as a reduction in benefits for the subscriber or the subscriber's dependent(s) due to a specific condition or ongoing course of treatment. A subscriber may not change their health plan if the subscriber's or an enrolled dependent's physician stops participation with the subscriber's health plan unless the PEBB ((~~appeals manager~~)) program determines that a continuity of care issue exists. The PEBB ((~~appeals manager will use~~)) program criteria ((~~that~~)) used will include, but ((~~are~~)) is not limited to, the following in determining if a continuity of care issue exists:

(i) Active cancer treatment; 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; or

(vi) Language barrier.

If the employee is having premiums taken from payroll on a pretax basis, a plan change will not be approved if it would conflict with provisions of the salary reduction plan authorized under RCW 41.05.300.

AMENDATORY SECTION (Amending Order 08-03, filed 10/1/08, effective 1/1/09)

WAC 182-08-199 When may an employee enroll in or change their election under the premium payment plan, medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP)? (1) When they are newly eligible under WAC 182-12-114, as described in WAC 182-08-197.

(2) **During annual open enrollment:** An eligible employee may enroll in or change their election under the state's premium payment plan, medical FSA or DCAP during the annual open enrollment. Employees must submit, in paper or on-line, the appropriate enrollment form((~~, or complete the appropriate on-line enrollment process,~~)) to reenroll no later than the end of the annual open enrollment. The enrollment or new election will begin January 1st of the following year.

((~~(2)~~)) (3) **During a special open enrollment:** Employees may enroll or change their election under the state's premium payment plan, medical FSA or DCAP outside of the annual open enrollment if a special open enrollment event occurs. The enrollment or change in enrollment must be allowable under Internal Revenue Code (IRC) and correspond to the event that creates the special open enrollment. To make a change or enroll, the employee must submit the appropriate forms as instructed on the forms no later than sixty days after the event occurs. Enrollment will begin the first day of the month following approval by the ((~~plan~~)) administrator. For purposes of this section, an eligible dependent includes the employee's opposite sex spouse and any other person who qualifies as the employee's dependent under Section 152 of the IRC without regard to the income limitations of that section. It does not include a Washington state registered domestic partner ((~~who is the same sex as the subscriber~~)) unless the domestic partner otherwise qualifies as a dependent under Section 152 of the IRC. The following

changes are events that create a special open enrollment for purposes of an eligible employee making a change:

(a) Employee acquires a new eligible dependent;

(b) Employee's dependent child becomes eligible by fulfilling PEBB dependent eligibility criteria;

(c) Employee loses an eligible dependent or a dependent no longer meets PEBB eligibility criteria;

(d) Employee has a change in marital status, including legal separation documented by a court order;

(e) Employee or a dependent has a change in employment status that affects the employee's or a dependent's eligibility, level of benefits, or cost of insurance coverage under a plan provided by the employee's employer or the dependent's employer;

(f) Employee's or a dependent's residence changes that affects health plan availability, level of benefits, or cost of insurance coverage;

(g) Employee receives a court order or medical support order requiring the employee or the employee's spouse to provide insurance coverage for an eligible dependent;

(h) Employee ((~~receives formal notice that~~)) or dependent becomes eligible for a medical assistance program under the department of social and health services ((~~has determined it is more cost-effective to enroll the eligible employee or eligible dependent in PEBB medical than in~~)), including medicaid or the children's health insurance program (CHIP), or the subscriber or dependent loses eligibility in such a medical assistance program;

(i) Seasonal employees whose off-season occurs during the annual open enrollment may enroll in the plan upon their return to work;

(j) Employee or an eligible dependent gains or loses eligibility for medicare or medicaid;

(k) The employee or the employee's spouse experiences a change in the number of qualifying individuals as defined in IRC Section 21 (b)(1);

(l) In addition to (a) through (k) of this section, the following are events that create a special open enrollment for purposes of an eligible employee making a change in his or her DCAP:

(i) Employees who change dependent care providers may make a change in their DCAP to reflect the cost of the new provider;

((~~(l)~~)) (ii) If an employee's dependent care provider imposes a change in the cost of dependent care, the employee may make a change in the DCAP to reflect the new cost if the dependent care provider is not a relative as defined in Section 152 (a)(1) through (8), incorporating the rules of Section 152 (b)(1) and (2) of the IRC((~~;~~

~~(m) The employee or the employee's spouse experiences a change in the number of qualifying individuals as defined in IRC Section 21 (b)(1)~~)).

AMENDATORY SECTION (Amending Order 07-01, filed 10/3/07, effective 11/3/07)

WAC 182-08-200 Which employing agency is responsible to pay the employer contribution for eligible employees changing agency employment or for faculty employed by more than one institution of higher education? Employing agencies responsible for paying the employer contribution:

(1) **For eligible employees changing agencies:** When an eligible employee's employment ((~~ceases~~)) relationship terminates with an employing agency at any time before the end of the month for which a premium contribution is due and that employee transfers to another agency, the losing agency is responsible for the payment of the contribution for that employee for that month. The receiving agency would not be liable for any employer contribution for that eligible employee until the month following the transfer.

(2) **For eligible faculty employed by more than one institution of higher education:**

(a) When a faculty is eligible for the employer contribution during an anticipated work period (quarter, semester or instructional year), under WAC 182-12-131(3), one institution will pay the entire cost of the employer contribution if the employee would be eligible by virtue of employment at that single institution. Otherwise:

(i) Each institution contributes based on its percentage of the employee's total work at all institutions during the anticipated work period.

(ii) The institution with the greatest percentage coordinates with the other institutions and is responsible for sending the total premium payment to HCA.

(b) When a faculty is eligible for the employer contribution during the summer or off-quarter/semester, under WAC 182-12-131 (3)(c), one institution will pay the entire cost of the employer contribution if the employee would be eligible by virtue of employment at that single institution. Otherwise:

(i) Each institution contributes based on its percentage of the employee's total work at all institutions throughout the instructional year or equivalent nine-month period.

(ii) The institution with the greatest percentage coordinates with the other institutions and is responsible for sending the total premium payment to HCA.

(c) When a faculty is eligible through two-year averaging under WAC 182-12-131 (3)(d) for the employer contribution, one institution will pay the entire cost of the employer contribution if the employee would be eligible by virtue of employment at that single institution. Otherwise:

(i) Each institution contributes to coverage based on its percentage of the employee's total work at all institutions throughout the preceding two academic years. This division of the employer contribution begins the summer quarter or semester following the second academic year and continues through that academic year or until eligibility under two-year averaging ceases.

Note: "Academic year" means summer, fall, winter, and spring quarters or summer, fall, and spring semesters, in that order.

(ii) The institution with the greatest percentage coordinates with the other institutions and is responsible for sending the total premium payment to HCA.

AMENDATORY SECTION (Amending Order 08-03, filed 10/1/08, effective 1/1/09)

WAC 182-08-230 Participation in PEBB benefits by employer groups, including K-12 school districts and educational service districts. This section applies to all

employer groups((~~, K-12 school districts and educational service districts participating in PEBB insurance coverage~~)) as defined in WAC 182-08-015.

(1)(((~~(a)~~))) Each employer group ((~~must~~)) determines ((~~an employee's~~)) employee and dependent eligibility for PEBB insurance coverage in accordance with the ((~~applicable sections of chapter 182-12 WAC, RCW 41.04.205, and chapter 41.05 RCW.~~

~~(b) Each employer group, K-12 school district and educational service district applying for participation in PEBB insurance coverage must submit required documentation and meet all participation requirements in the then-current *Introduction to PEBB Coverage K-12 and Employer Groups* booklet(s).~~

~~(2) Each employer group, K-12 school district or educational service district applying for participation in PEBB insurance coverage must sign an agreement with the HCA.~~

~~(3) At least twenty days before the premium due date, the HCA will cause each employer group, K-12 school district or educational service district to be sent a monthly billing statement. The statement of premium due will be based upon the enrollment information provided by the employer group, K-12 school district or educational service district.~~

~~(a) Changes in enrollment status must be submitted to the HCA before the twentieth day of the month when the change occurs. Changes submitted after the twentieth day of each month may not be reflected on the billing statement until the following month.~~

~~(b) Changes submitted more than one month late must be accompanied by a full explanation of the circumstances of the late notification.~~

~~(4) An employer group, K-12 school district or educational service district must remit the monthly premium as billed or as reconciled by it.~~

~~(a) If an employer group, K-12 school district or educational service district determines that the invoiced amount requires one or more changes, they may adjust the remittance only if an insurance eligibility adjustment form detailing the adjustment accompanies the remittance. The proper form for reporting adjustments will be attached to the agreement as Exhibit A.~~

~~(b) Each employer group, K-12 school district or educational service district is solely responsible for the accuracy of the amount remitted and the completeness and accuracy of the insurance eligibility adjustment form.~~

~~(5) Each employer group, K-12 school district or educational service district must remit the entire monthly premium due including the employee share, if any. The employer group, K-12 school district or educational service district is solely responsible for the collection of any employee share of the premium. The employer must not withhold portions of the monthly premium due because it has failed to collect the entire employee share.~~

~~(6) Nonpayment of the full premium when due will subject the employer group, K-12 school district or educational service district to disenrollment and termination of each employee of the group.~~

~~(a) Before termination for nonpayment of premium, the HCA will send a notice of overdue premium to the employer group, K-12 school district or educational service district which notice will provide a one-month grace period for payment of all overdue premium.~~

~~(b) An employer group, K-12 school district or educational service district that does not remit the entirety of its overdue premium no later than the last day of the grace period will be disenrolled effective the last day of the last month for which premium has been paid in full.~~

~~(c) Upon disenrollment, notification will be sent to both the employer group, K-12 school district or educational service district and each affected employee.~~

~~(d) Employer groups, K-12 school districts or educational service districts disenrolled due to nonpayment of premium have the right to a dispute resolution hearing in accordance with the terms of the agreement.~~

~~(e) Employees canceled due to the nonpayment of premium by the employer group, K-12 school district or educational service district are not eligible for continuation of group health plan coverage according to the terms of the Consolidated Omnibus Budget Reconciliation Act (COBRA). Employees whose coverage is canceled have conversion rights to an individual insurance policy as provided for by the employer group, K-12 school district or educational service district.~~

~~(f) Claims incurred by employees of a disenrolled group after the effective date of disenrollment will not be covered.~~

~~(g) The employer group, K-12 school district or educational service district is solely responsible for refunding any employee share paid by the employee to the employer group, K-12 school district or educational service district and not remitted to the HCA.~~

~~(7) A disenrolled employer group, K-12 school district or educational service district may apply for reinstatement in PEBB insurance coverage under the following conditions:~~

~~(a) Reinstatement must be requested and all delinquent premium paid in full no later than ninety days after the date the delinquent premium was first due, as well as a reinstatement fee of one thousand dollars.~~

~~(b) Reinstatement requested more than ninety days after the effective date of disenrollment will be denied.~~

~~(c) Employer groups, K-12 school districts or educational service districts may be reinstated only once in any two-year period and will be subject to immediate disenrollment if, after the effective date of any such reinstatement, subsequent premiums become more than thirty days delinquent.~~

~~(8) Upon written petition by the employer group, K-12 school district or educational service district disenrollment of an employer group, K-12 school district or educational service district or denial of reinstatement may be waived by the administrator upon a showing of good cause.~~)) criteria outlined in its contract with HCA.

(2) Each employer group is responsible for premium payments and billing arrangements in accordance with the criteria outlined in its contract with HCA.

AMENDATORY SECTION (Amending Order 08-03, filed 10/1/08, effective 1/1/09)

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.

"Agency" means the health care authority.

"Benefits eligible position" means any position held by an employee who is eligible for benefits under WAC 182-12-114, with the exception of employees who establish eligibility under WAC 182-12-114 (2) or (3)(a)(ii).

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

"Comprehensive employer sponsored medical" includes insurance coverage continued by the employee or their dependent under COBRA. It does not include an employer's retiree coverage, with the exception of a federal retiree plan.

"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 medical insurance by a retiree or eligible survivor.

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

"Dependent care assistance program" or "DCAP" means a benefit plan whereby state and public employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan authorized in chapter 41.05 RCW.

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

"Employer group" means those employee organizations representing state civil service employees, counties, municipalities, political subdivisions, tribal governments, school districts, and educational service districts participating in PEBB insurance coverage under contract as described in WAC 182-08-230.

"Employing agency" means a division, department, or separate agency of state government, including an institution of higher education; a county, municipality, school district, educational service district, or other political subdivision; or a tribal government covered by chapter 41.05 RCW.

((~~"Employer group" means those employee organizations representing state civil service employees, blind vendors, counties, municipalities, political subdivisions, and tribal governments participating in PEBB insurance coverage under contractual agreement as described in WAC 182-08-230.~~))

"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.

"Faculty" means an academic employee of an institution of higher education whose workload is not defined by work hours but whose appointment, workload, and duties directly serve the institution's academic mission, as determined under the authority of its enabling statutes, its governing body, and any applicable collective bargaining agreement.

"Health plan" or "plan" means a medical or dental plan developed by the public employees benefits board and provided by a contracted vendor or self-insured plans administered by the HCA.

"Institutions of higher education" means the state public research universities, the public regional universities, The Evergreen State College, the community and technical colleges, and includes the higher education personnel board and the state board for community and technical colleges.

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

"Layoff" means a change in employment status due to an employer's lack of funds or an employer's organizational change.

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

"Life insurance" includes basic life insurance paid for by the ((~~employer~~)) employing agency, life insurance offered to employees on an optional basis, and retiree life insurance.

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby state and public employees may reduce their salary before taxes to pay for medical expenses not reimbursed by insurance as provided in the salary reduction plan authorized in chapter 41.05 RCW.

"Open enrollment" means a time period when: Subscribers may apply to transfer their enrollment from one health plan to another; a dependent may be enrolled; a ((~~dependent's enrollment~~)) dependent may be ((~~waived~~)) removed from coverage; or an employee who previously waived medical may enroll in medical. Open enrollment is also the time when employees may enroll in or change their election under the DCAP, the medical FSA, or the premium payment plan. An "annual" open enrollment, designated by the administrator, is an open enrollment when all PEBB subscribers may make enrollment changes for the upcoming year. A "special" open enrollment is triggered by a specific life event. For special open enrollment events as they relate to specific PEBB benefits, see WAC 182-08-198, 182-08-199, 182-12-128, 182-12-262.

"PEBB" means the public employees benefits board.

"PEBB appeals committee" means the committee that considers appeals relating to the administration of PEBB benefits by the PEBB ((~~benefits services~~)) program. The administrator has delegated the authority to hear appeals at the level below an administrative hearing to the PEBB appeals committee.

"PEBB benefits" means one or more insurance coverage or other employee benefit administered by the PEBB ((~~benefits services~~)) program within HCA.

"PEBB ((~~benefits services~~)) program" means the program within the ((~~health care authority~~)) HCA which administers insurance and other benefits for eligible employees of the state (as defined in WAC ((~~182-12-115~~)) 182-12-114), eligible retired and disabled employees (as defined in WAC

182-12-171), eligible dependents (as defined in WAC 182-12-250 and 182-12-260) and others as defined in RCW 41.05.011.

"Premium payment plan" means a benefit plan whereby state and public employees may pay their share of group health plan premiums with pretax dollars as provided in the salary reduction plan.

"Salary reduction plan" means a benefit plan whereby state and public employees may agree to a reduction of salary on a pretax basis to participate in the DCAP, medical FSA, or premium payment plan as authorized in chapter 41.05 RCW.

"Seasonal employee" means an employee hired to work during a recurring, annual season with a duration of three months or more, and anticipated to return each season to perform similar work.

"State agency" means an office, department, board, commission, institution, or other separate unit or division, however designated, of the state government and all personnel thereof. It includes the legislature, executive branch, and agencies or courts within the judicial branch, as well as institutions of higher education and any unit of state government established by law.

"Subscriber" ((~~or "insured"~~)) means the employee, retiree, COBRA beneficiary or eligible survivor who has been designated by the HCA as the individual to whom the HCA and contracted vendors will issue all notices, information, requests and premium bills on behalf of enrollees.

"Termination of the employment relationship" means that an employee resigns or an employee is terminated and the employing agency has no anticipation that the employee will be rehired.

"Tribal government" means an Indian tribal government as defined in Section 3(32) of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, or an agency or instrumentality of the tribal government, that has government offices principally located in this state.

"Waive" means to interrupt an eligible employee's enrollment ((~~or postpone enrollment~~)) in a PEBB health plan ((~~by an~~)) because the employee (((~~as defined in WAC 182-12-115) or a dependent who meets eligibility requirements in WAC 182-12-260~~)) is enrolled in other comprehensive group coverage or is on approved educational leave (see WAC 182-12-128 and 182-12-136).

AMENDATORY SECTION (Amending Order 08-03, filed 10/1/08, effective 1/1/09)

WAC 182-12-111 Eligible entities and individuals. The following entities and individuals shall be eligible for PEBB insurance coverage 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, the higher education coordinating board, and the state board for community and technical colleges is~~)) State agencies, as defined in WAC 182-12-109, are required to participate in all PEBB benefits. Insurance and health care contributions for ferry employees shall be governed by RCW 47.64.270.

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

(b) Community and 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) ((~~Employee organizations. Employee organizations representing state civil service employees and, effective October 1, 1995, employees of employee organizations currently pooled with employees of school districts for purchasing insurance benefits,~~)) Employer groups: Employer groups may participate in PEBB insurance coverages at the option of each ((~~employee organization~~)) employer group provided all of the following requirements are met:

(a) All eligible employees of the entity must transfer to PEBB insurance coverage as a unit with the following exceptions:

• Bargaining units may elect to participate separately from the whole group; and

• Nonrepresented employees may elect to participate separately from the whole group provided all nonrepresented employees join as a group.

(b) PEBB health plans must be the only employer sponsored health plans available to eligible employees.

(c) The ((~~legislative authority or the board of directors of the entity~~)) employer group must submit to the HCA an application ((~~together with employee census data and, if available, prior claims experience of the entity~~)) when it first applies, the contents of which will be specified by HCA. The application ((~~for PEBB insurance coverage~~)) for employer groups, with the exception of school districts and educational service districts, is subject to ((~~the~~)) review and approval ((~~of~~)) by the HCA, and the decision to approve or deny the application shall be provided to the applying employer group by the HCA.

(d) Each employer group purchasing PEBB insurance coverage must sign a contract with the HCA. The employer group must abide by the eligibility, enrollment, and payment terms specified in the contract. Any subsequent changes to the contract must be submitted for approval in advance of the change.

(e) The ((~~legislative authority or the board of directors~~)) employer group must maintain its PEBB insurance coverage participation at least one full year, and may end participation only at the end of a plan year.

(((~~(e) The terms and conditions for the payment of the insurance premiums must be in the provisions of a bargaining agreement or terms of employment and shall comply with the employer contribution requirements specified in the appropriate governing statute. These provisions, including eligibility, shall be subject to review and approval by the HCA at the~~

~~time of application for participation. Any substantive changes must be submitted to HCA.~~

~~(f) The eligibility requirements for dependents must be the same as the requirements for dependents of the state employees and retirees as in WAC 182-12-260.~~

~~(g)~~)) (f) The ((~~legislative authority or the board of directors~~)) employer group must give the HCA written notice of its intent to end PEBB insurance coverage participation at least sixty days before the effective date of termination. With the exception of retired and disabled employees of school districts or educational service districts, if the ((~~employee organization~~)) employer group ends PEBB insurance coverage, retired and disabled employees who began participating after September 15, 1991, are not eligible for PEBB insurance coverage beyond the mandatory extension requirements specified in WAC 182-12-146.

(((~~(h)~~))) (g) Employees eligible for PEBB participation include only those employees whose services are substantially all in the performance of essential governmental functions but not in the performance of commercial activities, whether or not those activities qualify as essential governmental functions. Employer((~~s~~)) groups shall determine eligibility in order to ensure PEBB's continued status as a governmental plan under Section 3(32) of the Employee Retirement Income Security Act of 1974 (ERISA) as amended.

(3) School districts and educational service districts: In addition to subsection (2) of this section, the following applies to school districts and educational service districts:

(a) The HCA will collect an amount equal to the composite rate charged to state agencies plus an amount equal to the employee premium by health plan and family size as would be charged to state employees for each participating school district or educational service district.

(b) Each participating school district or educational service district must agree to collect an employee premium by health plan and family size that is not less than that paid by state employees.

(c) The HCA may collect these amounts in accordance with the district fiscal year, as described in RCW 28A.505.030.

(4) Blind vendors means a "licensee" as defined in RCW 74.18.200: Vendors actively operating a business enterprise program facility in the state of Washington and deemed eligible by the department of services for the blind may voluntarily participate in PEBB insurance coverage.

(a) Vendors that do not enroll when first eligible may enroll only during the annual open enrollment period offered by the HCA or the first day of the month following loss of other insurance coverage.

(b) Department of services for the blind will notify eligible vendors of their eligibility in advance of the date that they are eligible to apply for enrollment in PEBB insurance coverage.

(c) The eligibility requirements for dependents of blind vendors shall be the same as the requirements for dependents of the state employees and retirees in WAC 182-12-260.

(((~~(4) Local governments: Employees of a county, municipality, or other political subdivision of the state may participate in PEBB insurance coverage provided all of the following requirements are met:~~

~~(a) All eligible employees of the entity must transfer to PEBB insurance coverage as a unit with the following exception:~~

~~• Bargaining units may elect to participate separately from the whole group; and~~

~~• Nonrepresented employees may elect to participate separately from the whole group provided all nonrepresented employees join as a group.~~

~~(b) The PEBB health plans must be the only employer sponsored health plans available to eligible employees.~~

~~(c) The legislative authority or the board of directors of the entity must submit to the HCA an application together with employee census data and, if available, prior claims experience of the entity. The application for PEBB insurance coverage is subject to the approval of the HCA.~~

~~(d) The legislative authority or the board of directors must maintain its PEBB insurance coverage participation at least one full year, and may terminate participation only at the end of the plan year.~~

~~(e) The terms and conditions for the payment of the insurance premiums must be in the provisions of a bargaining agreement or terms of employment and shall comply with the employer contribution requirements specified in the appropriate governing statute. These provisions, including eligibility, shall be subject to review and approval by the HCA at the time of application for participation. Any substantive changes must be submitted to HCA.~~

~~(f) The eligibility requirements for dependents of local government employees must be the same as the requirements for dependents of state employees and retirees in WAC 182-12-260.~~

~~(g) The legislative authority or the board of directors must give the HCA written notice of its intent to end PEBB insurance coverage participation at least sixty days before the effective date of termination. If a county, municipality, or political subdivision ends PEBB insurance coverage, retired and disabled employees who began participating after September 15, 1991, are not eligible for PEBB insurance coverage beyond the mandatory extension requirements specified in WAC 182-12-146.~~

~~(h) Employees eligible for PEBB participation include only those employees whose services are substantially all in the performance of essential governmental functions but not in the performance of commercial activities, whether or not those activities qualify as essential governmental functions. Employers shall determine eligibility in order to ensure PEBB's continued status as a governmental plan under Section 3(32) of the Employee Retirement Income Security Act of 1974 (ERISA) as amended.~~

~~(5) K-12 school districts and educational service districts: Employees of school districts or educational service districts may participate in PEBB insurance coverage provided all of the following requirements are met:~~

~~(a) All eligible employees of the K-12 school district or educational service district must transfer to PEBB insurance coverage as a unit with the following exceptions:~~

~~• Bargaining units may elect to participate separately from the whole group; and~~

~~• Nonrepresented employees may elect to participate separately from the whole group provided all nonrepresented employees join as a group.~~

~~(b) The school district or educational service district must submit an application together with an estimate of the number of employees and dependents to be enrolled. The application for the PEBB insurance coverage is subject to review for compliance with PEBB terms and conditions of participation.~~

~~(c) The school district or educational service district must agree to participate in all PEBB insurance coverage. The PEBB health plans must be the only employer sponsored health plans available to eligible employees.~~

~~(d) The school district or educational service district must maintain its PEBB insurance coverage participation at least one full year, and may end participation only at the end of the plan year.~~

~~(e) Beginning September 1, 2003, the HCA will collect an amount equal to the composite rate charged to state agencies plus an amount equal to the employee premium by health plan and family size as would be charged to state employees for each participating school district or educational service district. Each participating school district or educational service district must agree to collect an employee premium by health plan and family size that is not less than that paid by state employees. The eligibility requirements for employees will be the same as those for state employees as defined in WAC 182-12-115.~~

~~(f) The eligibility requirements for dependents of K-12 school district and educational service district employees must be the same as the requirements for dependents of the state employees and retirees in WAC 182-12-260.~~

~~(g) The school district or educational service district must give the HCA written notice of its intent to end PEBB insurance coverage participation at least sixty days before the effective date of termination, and may end participation only at the end of a plan year.~~

~~(h) Employees eligible for PEBB participation include only those employees whose services are substantially all in the performance of essential governmental functions but not in the performance of commercial activities, whether or not those activities qualify as essential governmental functions. Employers shall determine eligibility in order to ensure PEBB's continued status as a governmental plan under Section 3(32) of the Employee Retirement Income Security Act of 1974 (ERISA) as amended.~~

~~(6) Tribal governments: Employees of a tribal government, or an agency or instrumentality of a tribal government, may participate in PEBB insurance coverage provided all of the following requirements are met:~~

~~(a) All eligible employees of the entity must transfer to PEBB insurance as a unit with the following exceptions:~~

~~• Bargaining units may elect to participate separately from the whole group; and~~

~~• Nonrepresented employees may elect to participate separately from the whole group provided all nonrepresented employees join as a group.~~

~~(b) The PEBB health plans must be the only employer sponsored health plans available to eligible employees.~~

~~(c) The tribal council or the board of directors of the entity must submit to the HCA an application together with employee census data and, if available, prior claims experience of the entity. The application for PEBB insurance coverage is subject to the approval of the HCA.~~

~~(d) The tribal council or the board of directors must maintain its PEBB insurance coverage participation at least one full year, and may terminate participation only at the end of the plan year.~~

~~(e) The terms and conditions for the payment of the insurance premiums must be in the provisions of a bargaining agreement or terms of employment and shall comply with the employer contribution requirements specified in the appropriate governing statute. These provisions, including eligibility, shall be subject to review and approval by the HCA at the time of application for participation. Any substantive changes must be submitted to HCA.~~

~~(f) The eligibility requirements for dependents of tribal government employees must be the same as the requirements for dependents of state employees and retirees in WAC 182-12-260.~~

~~(g) The tribal council or the board of directors must give the HCA written notice of its intent to end PEBB insurance coverage participation at least sixty days before the effective date of termination. If a tribal government, or an agency or instrumentality of a tribal government, ends PEBB insurance coverage, retired and disabled employees are not eligible for PEBB insurance coverage beyond the mandatory extension requirements specified in WAC 182-12-146.~~

~~(h) Employees eligible for PEBB participation include only those employees whose services are substantially all in the performance of essential governmental functions but not in the performance of commercial activities, whether or not those activities qualify as essential governmental functions. Employers shall determine eligibility in order to ensure PEBB's continued status as a governmental plan under Section 3(32) of the Employee Retirement Income Security Act of 1974 (ERISA) as amended.~~

~~(7)~~)) (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 health plans while enrolled in that program.

(b) School board members or students eligible to participate under RCW 28A.400.350 may participate in PEBB insurance coverage as long as they remain eligible under that section.

(6) Individuals that are not eligible include:

(a) Adult family home providers as defined in RCW 70.128.010;

(b) Unpaid volunteers;

(c) Patients of state hospitals;

(d) Inmates;

(e) Employees of the Washington state convention and trade center as provided in RCW 41.05.110;

(f) Students of institutions of higher education as determined by their institutions; and

(g) Any others not expressly defined as employees under RCW 41.05.011.

NEW SECTION

WAC 182-12-113 What are the obligations of a state agency in the application of employee eligibility? (1) All state agencies must carry out all actions, policies, and guidance issued by the PEBB program necessary for the operation of benefit plans, education of employees, claims administration, and appeals process including that described in chapters 182-08, 182-12, and 182-16 WAC. State agencies must:

(a) Use the methods provided by the PEBB program to determine eligibility and enrollment in benefits, unless otherwise approved in writing;

(b) Provide eligibility determination reports with content and in a format designed and communicated by the PEBB program or otherwise as approved in writing by the PEBB program; and

(c) Carry out corrective action and pay any penalties imposed by the authority and established by the board when the state agency's eligibility determinations fail to comply with the criteria under these rules.

(2) All state agencies must determine employee eligibility for PEBB benefits and employer contribution according to the criteria in WAC 182-12-114 and 182-12-131. State agencies must:

(a) Notify newly hired employees of PEBB rules and guidance for eligibility and appeal rights;

(b) Provide written notice to faculty who are potentially eligible for benefits and employer contribution of their potential eligibility under WAC 182-12-114(3) and 182-12-131;

(c) Inform an employee in writing whether or not he or she is eligible for benefits upon employment. The written communication must include a description of any hours that are excluded in determining eligibility and information about the employee's right to appeal eligibility and enrollment decisions;

(d) Routinely monitor all employees' eligible work hours to establish eligibility and maintain the employer contribution toward insurance coverage;

(e) Make eligibility determinations based on the criteria of the eligibility category that most closely describes the employee's work circumstances per the PEBB program's direction;

(f) Identify when a previously ineligible employee becomes eligible or a previously eligible employee loses eligibility; and

(g) Inform an employee in writing whether or not he or she is eligible for benefits and the employer contribution whenever there is a change in work patterns such that the employee's eligibility status changes. At the same time, state agencies must inform employees of the right to appeal eligibility and enrollment decisions.

NEW SECTION

WAC 182-12-114 How do employees establish eligibility for PEBB benefits? Eligibility for an employee whose work circumstances are described by more than one of the eligibility categories in subsections (1) through (5) of this section shall be determined solely by the criteria of the category that most closely describes the employee's work circumstances.

Hours that are excluded in determining eligibility include standby hours and any temporary increases in work hours, of six months or less, caused by training or emergencies that have not been or are not anticipated to be part of the employee's regular work schedule or pattern. Employing agencies must request the PEBB program's approval to include temporary training or emergency hours in determining eligibility.

For how the employer contribution toward insurance coverage is maintained after eligibility is established under this section, see WAC 182-12-131.

(1) Employees are eligible for PEBB benefits as follows, except as provided in subsections (2) through (5) of this section:

(a) **Eligibility.** An employee is eligible if he or she works an average of at least eighty hours per month and works for at least eight hours in each month for more than six consecutive months.

(b) **Determining eligibility.**

(i) **Upon employment:** An employee is eligible from the date of employment if the employing agency anticipates the employee will work according to the criteria in (a) of this subsection.

(ii) **Upon revision of anticipated work pattern:** If an employing agency revises an employee's anticipated work hours such that the employee meets the eligibility criteria in (a) of this subsection, the employee becomes eligible when the revision is made.

(iii) **Based on work pattern:** An employee who is determined to be ineligible, but later meets the eligibility criteria in (a) of this subsection, becomes eligible the first of the month following the six-month averaging period.

(c) **Stacking of hours.** As long as the work is within one state agency, employees may "stack" or combine hours worked in more than one position or job to establish eligibility and maintain the employer contribution toward insurance coverage. Employees must notify their employing agency if they believe they are eligible through stacking. Stacking includes work situation in which:

(i) The employee works two or more positions or jobs at the same time (concurrent stacking);

(ii) The employee moves from one position or job to another (consecutive stacking); or

(iii) The employee combines hours from a seasonal position to hours from a nonseasonal position or job. An employee who establishes eligibility by stacking hours from a seasonal position or job with hours from a nonseasonal position or job shall maintain the employer contribution toward insurance coverage under WAC 182-12-131(1).

(d) **When PEBB benefits begin.** PEBB benefits begin on the first day of the month following the date an employee becomes eligible. If the employee becomes eligible on the first working day of a month, PEBB benefits begin on that date.

(2) **Seasonal employees,** as defined in WAC 182-12-109, are eligible as follows:

(a) **Eligibility.** A seasonal employee is eligible if he or she works an average of at least eighty hours per month and works for at least eight hours in each month of the season. A

season is any recurring, cyclical period of work at a specific time of year that lasts three to eleven months.

(b) **Determining eligibility.**

(i) **Upon employment:** A seasonal employee is eligible from the date of employment if the employing agency anticipates that he or she will work according to the criteria in (a) of this subsection.

(ii) **Upon revision of anticipated work pattern.** If an employing agency revises an employee's anticipated work hours such that the employee meets the eligibility criteria in (a) of this subsection, the employee becomes eligible when the revision is made.

(iii) **Based on work pattern.** An employee who is determined to be ineligible for benefits, but later works an average of at least eighty hours per month and works for at least eight hours in each month and works for more than six consecutive months, becomes eligible the first of the month following a six-month averaging period.

(c) **Stacking of hours.** As long as the work is within one state agency, employees may "stack" or combine hours worked in more than one position or job to establish eligibility and maintain the employer contribution toward insurance coverage. Employees must notify their employing agency if they believe they are eligible through stacking. Stacking includes work situations in which:

(i) The employee works two or more positions or jobs at the same time (concurrent stacking);

(ii) The employee moves from one position or job to another (consecutive stacking); or

(iii) The employee combines hours from a seasonal position or job to hours from a nonseasonal position or job. An employee who establishes eligibility by stacking hours from a seasonal position or job with hours from a nonseasonal position or job shall maintain the employer contribution toward insurance coverage under WAC 182-12-131(1).

(d) **When PEBB benefits begin.** PEBB benefits begin on the first day of the month following the day the employee becomes eligible. If the employee becomes eligible on the first working day of a month, PEBB benefits begin on that date.

(3) **Faculty** are eligible as follows:

(a) **Determining eligibility.** "Half-time" means one-half of the full-time academic workload as determined by each institution, except that half-time for community and technical college faculty employees is governed by RCW 28B.50.489.

(i) **Upon employment:** Faculty who the employing agency anticipates will work half-time or more for the entire instructional year, or equivalent nine-month period, are eligible from the date of employment.

(ii) **For faculty hired on quarter/semester to quarter/semester basis:** Faculty who the employing agency anticipates will not work for the entire instructional year, or equivalent nine-month period, are eligible at the beginning of the second consecutive quarter or semester of employment in which he or she is anticipated to work, or has actually worked, half-time or more. Spring and fall may be considered consecutive quarters/semesters when first establishing eligibility.

(iii) **Upon revision of anticipated work pattern:** Faculty who receive additional workload after the beginning of the anticipated work period (quarter, semester, or instructional year), such that their workload meets the eligibility criteria of (a)(i) or (ii) of this subsection become eligible when the revision is made.

(b) **Stacking.** Faculty may establish eligibility and maintain the employer contribution toward insurance coverage by working as faculty for more than one institution of higher education. When a faculty works for more than one institution of higher education, the faculty must notify his or her employing agencies that he or she works at more than one institution and may be eligible through stacking.

(c) **PEBB benefits begin.**

(i) PEBB benefits begin on the first day of the month following the day the faculty becomes eligible. If the faculty becomes eligible on the first working day of a month, PEBB benefits begin on that date.

(ii) For faculty hired on a quarter/semester to quarter/semester basis under (a)(ii) of this subsection, PEBB benefits begin the first day of the month following the beginning of the second quarter/semester of half-time or more employment. If the first day of the second consecutive quarter/semester is the first working day of the month, PEBB benefits begin at the beginning of the second consecutive quarter/semester.

(4) **Elected and full-time appointed officials of the legislative and executive branches of state government** are eligible as follows:

(a) **Eligibility.** A legislator is eligible for PEBB benefits on the date his or her term begins. All other elected and full-time appointed officials of the legislative and executive branches of state government are eligible on the date their terms begin or the date they take the oath of office, whichever occurs first.

(b) **PEBB benefits begin.** PEBB benefits for an eligible employee begin on the first day of the month following the day he or she becomes eligible. If the employee becomes eligible on the first working day of a month, PEBB benefits begin on that date.

(5) **Justices and judges** are eligible as follows:

(a) **Eligibility.** A justice of the supreme court and judges of the court of appeals and the superior courts become eligible for PEBB benefits on the date they take the oath of office.

(b) **PEBB benefits begin.** PEBB benefits for an eligible employee begin on the first day of the month following the day he or she becomes eligible. If the employee becomes eligible on the first working day of a month, PEBB benefits begin on that date.

AMENDATORY SECTION (Amending Order 08-03, filed 10/1/08, effective 1/1/09)

WAC 182-12-116 Who is eligible to participate in the state's salary reduction plan? (1) ((~~The following~~)) Employees of state agencies are eligible to participate in the state's salary reduction plan provided they are eligible for PEBB benefits as defined in WAC ((~~182-12-115~~)) 182-12-114 and they elect to participate within the time frames described in WAC 182-08-197 or 182-08-199.

((~~(a) Employees of public four-year institutions of higher education.~~

~~(b) Employees of the state community and technical colleges and of the state board for community and technical colleges.~~

~~(c) Employees of state agencies.~~))

(2) Employees of employer groups, ((~~K-12 school districts and educational service districts~~)) as defined in WAC 182-12-109, are not eligible to participate in the state's salary reduction plan.

AMENDATORY SECTION (Amending Order 07-01, filed 10/3/07, effective 11/3/07)

WAC 182-12-123 Dual enrollment is prohibited. PEBB health plan coverage is limited to a single enrollment per individual.

(1) Effective January 1, 2002, individuals who have more than one source of eligibility for enrollment in PEBB health plan coverage (called "dual eligibility") are limited to one enrollment.

(2) An eligible employee may waive medical and enroll as a dependent on the coverage of his or her eligible spouse ((~~or qualified~~)), eligible Washington state registered domestic partner, or eligible parent as stated in WAC 182-12-128.

(3) Children eligible for medical and dental under two ((~~or more parents or stepparents, who are employed by PEBB-participating employers,~~)) subscribers may be enrolled as a dependent under the health plan of only one ((~~parent or stepparent, but not more than one~~)) subscriber.

(4) An employee ((~~employed in a benefits eligible position by~~)) who is eligible for the employer contribution to PEBB benefits due to employment in more than one PEBB-participating ((~~employer~~)) employing agency may enroll only under one ((~~employer~~)) employing agency. The employee ((~~may~~)) must choose to enroll in PEBB benefits under ((~~the employer that:~~

~~(a) Offers the most favorable cost-sharing arrangement; or~~

~~(b) Employed the employee for the longer period of time~~)) only one employing agency.

Exception: Faculty who stack to establish or maintain eligibility under WAC 182-12-114(3) with two or more state institutions of higher education will be enrolled according to WAC 182-08-200(2).

AMENDATORY SECTION (Amending Order 08-03, filed 10/1/08, effective 1/1/09)

WAC 182-12-128 May an employee waive health plan enrollment? ((~~(1)~~)) Employees must enroll in dental, life and long-term disability insurance (unless the employing agency does not participate in these PEBB insurance coverages). However, employees may waive PEBB medical if they have other comprehensive group medical coverage.

(1) Employees may waive enrollment in PEBB medical by submitting the appropriate enrollment form to their employing agency during the following times:

(a) **When the employee becomes eligible:** Employees may waive medical when they become eligible for PEBB benefits. Employees must indicate they are waiving medical on the appropriate enrollment form they submit to their employing agency no later than thirty-one days after the date they become eligible (see WAC 182-08-197). Medical will be waived as of the date the employee becomes eligible for PEBB benefits.

(b) **During the annual open enrollment:** Employees may waive medical during the annual open enrollment if they submit the appropriate enrollment form to their employing agency before the end of the annual open enrollment. Medical will be waived beginning January 1st of the following year.

(c) **During a special open enrollment:** Employees may waive medical during a special open enrollment as described in subsection (4) of this section.

(2) If an employee waives medical, ((~~medical is automatically waived for all~~)) the employee's eligible dependents may not be enrolled in medical, with the exception of adult dependents who may enroll in a health plan if the employee has waived medical coverage.

(3) Once medical is waived, enrollment is only allowed during the following times:

(a) During the annual open enrollment ((~~period~~));

(b) During a special open enrollment created by an event that allows for enrollment outside of the annual open enrollment as described in subsection (4) of this section. In addition to the appropriate forms, the PEBB ((~~benefits services~~)) program may require the employee to provide evidence of eligibility and evidence of the event that creates a special open enrollment.

(4) **Special open enrollment:** Employees may waive enrollment in medical or enroll in medical if one of these special open enrollment events occur. The change in enrollment must correspond to the event that creates the special open enrollment. The following changes are events that create a special open enrollment:

(a) Employee acquires a new eligible dependent through marriage, registering a domestic partnership with Washington state, birth, adoption or ((~~placement for~~)) when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption, legal custody or legal guardianship;

(b) Employee's dependent child becomes eligible by fulfilling PEBB dependent eligibility criteria;

(c) Employee loses an eligible dependent or a dependent no longer meets PEBB eligibility criteria;

(d) Employee has a change in marital status or Washington state registered domestic partnership status, including legal separation documented by a court order;

(e) Employee or a dependent loses comprehensive group insurance coverage;

(f) Employee or a dependent has a change in employment status that affects the employee's or a dependent's eligibility, level of benefits, or cost of insurance coverage;

(g) Employee or a dependent has a change in place of residence that affects the employee's or a dependent's eligibility, level of benefits, or cost of insurance coverage;

(h) Employee receives a court order or medical support enforcement order requiring the employee, spouse, or qualified domestic partner to enroll an eligible dependent;

(i) Employee ((~~receives formal notice that~~)) or dependent becomes eligible for a medical assistance program under the department of social and health services ((~~has determined~~

~~it is more cost-effective to enroll~~)), including medicaid or the children's health insurance program (CHIP), or the employee or ((~~an eligible~~)) dependent ((~~in PEBB medical than~~)) loses eligibility in a medical assistance program.

To ((~~change enrollment~~)) waive or enroll during a special open enrollment, the employee must submit the appropriate forms to their employing agency no later than sixty days after the event that creates the special open enrollment.

Enrollment in insurance coverage will begin the first of the month following the event that created the special open enrollment; or in cases where the event occurs on the first day of a month, enrollment will begin on that date. If the special open enrollment is due to the birth or adoption of a child, insurance coverage will begin the month in which the event occurs.

NEW SECTION

WAC 182-12-129 What happens when an employee moves from an eligible to an otherwise ineligible position or job due to a layoff? This section applies to employees employed by state agencies (as defined in this chapter), including benefits-eligible seasonal employees, and is intended to address situations where an employee moves from one position or job to another due to a layoff, as defined in WAC 182-12-109. This section does not apply to employees with an anticipated end date.

If an employee moves from an eligible to an otherwise ineligible position due to layoff, the employee may retain his or her eligibility for the employer contribution toward insurance coverage for each month that the employee is in pay status for at least eight hours. To maintain eligibility using this section the employee must:

• Be hired into a position with a state agency within twenty-four months of the original eligible position ending; and

• Upon hire, notify the employing agency that he or she is potentially eligible to use this section.

This section ceases to apply if the employee is employed in a position eligible for PEBB benefits under WAC 182-12-114 within twenty-four months of leaving the original position.

After the twenty-fourth month, the employee must reestablish eligibility under WAC 182-12-114.

AMENDATORY SECTION (Amending Order 07-01, filed 10/3/07, effective 11/3/07)

WAC 182-12-131 ((~~When does~~)) How do eligible employees maintain the employer ((~~paid~~)) contribution toward insurance coverage ((~~end~~))? The employer contribution toward insurance coverage begins on the day that PEBB benefits begin under WAC 182-12-114. This section describes under what circumstances an employee maintains eligibility for the employer contribution toward PEBB benefits.

(1) **Maintaining the employer contribution.** Except as described in subsections (2), (3) and (4) of this section, an employee who has established eligibility for benefits under WAC 182-12-114 is eligible for the employer contribution each month in which he or she is in pay status eight or more hours per month.

(2) **Maintaining the employer contribution - benefits-eligible seasonal employees.**

(a) A benefits-eligible seasonal employee (eligible under WAC 182-12-114(2)) who works a season of less than nine months is eligible for the employer contribution in any month of his or her season in which he or she is in pay status eight or more hours during that month. The employer contribution toward PEBB benefits for seasonal employees returning after their off season begins on the first day of the first month of the season in which they are in pay status eight hours or more.

(b) A benefits-eligible seasonal employee (eligible under WAC 182-12-114(2)) who works a season of nine months or more is eligible for the employer contribution through the off season following each season worked.

(3) **Maintaining the employer contribution - eligible faculty.**

(a) Benefits-eligible faculty anticipated to work the entire instructional year or equivalent nine-month period (eligible under WAC 182-12-114 (3)(a)(i)) are eligible for the employer contribution each month of the instructional year, except as described in subsection (7) of this section.

(b) Benefits-eligible faculty who are hired on a quarter/semester to quarter/semester basis (eligible under WAC 182-12-114 (3)(a)(ii)) are eligible for the employer contribution each quarter or semester in which the employee works half-time or more.

(c) Summer or off-quarter/semester coverage: All benefits-eligible faculty (eligible under WAC 182-12-114(3)) who work an average of half-time or more throughout the entire instructional year or equivalent nine-month period and work each quarter/semester of the instructional year or equivalent nine-month period are eligible for the employer contribution toward summer or off-quarter/semester insurance coverage.

Exception: Eligibility for the employer contribution toward summer or off-quarter/semester insurance coverage ends on the end date specified in an employing agency's termination notice or an employee's resignation letter, whichever is earlier, if the employing agency has no anticipation that the employee will be returning as faculty at any institution of higher education where the employee has employment.

(d) Two-year averaging: All benefits-eligible faculty (eligible under WAC 182-12-114(3)) who worked an average of half-time or more in each of the two preceding academic years are potentially eligible to receive uninterrupted employer contribution to PEBB benefits. "Academic year" means summer, fall, winter, and spring quarters or summer, fall, and spring semesters and begins with summer quarter/semester. In order to be eligible for the employer contribution through two-year averaging, the faculty must provide written notification of his or her potential eligibility to his or her employing agency or agencies within the deadlines established by the employing agency or agencies. Faculty continue to receive uninterrupted employer contribution for each academic year in which they:

(i) Are employed on a quarter/semester to quarter/semester basis and work at least two quarters or two semesters; and

(ii) Have an average workload of half-time or more for three quarters or two semesters.

Eligibility for the employer contribution under two-year averaging ceases immediately if the eligibility criteria is not met or if the eligibility criteria becomes impossible to meet.

(e) Faculty with gaps of eligibility for the employer contribution: All benefits-eligible faculty (eligible under WAC 182-12-114(3)) who lose eligibility for the employer contribution will regain it if they return to a faculty position where it is anticipated that they will work half-time or more for the quarter/semester no later than the twelfth month after the month in which they lost eligibility for the employer contribution. The employer contribution begins on the first day of the month in which the quarter/semester begins.

(4) **Maintaining the employer contribution - employees on leave and under the special circumstances listed below.**

(a) Employees who are on approved leave under the federal Family and Medical Leave Act (FMLA) continue to receive the employer contribution as long as they are approved under the act.

(b) Unless otherwise indicated in this section, employees in the following circumstances receive the employer contribution only for the months they are in pay status eight hours or more:

(i) Employees on authorized leave without pay;

(ii) Employees on approved educational leave;

(iii) Employees receiving time-loss benefits under workers' compensation;

(iv) Employees called to active duty in the uniformed services as defined under the Uniformed Services Employment and Reemployment Rights Act (USERRA); or

(v) Employees applying for disability retirement.

(5) **Maintaining the employer contribution - employees who move from an eligible to an otherwise ineligible position due to a layoff** maintain the employer contribution toward insurance coverage under the criteria in WAC 182-12-129.

(6) **Employees who are in pay status less than eight hours in a month.** Unless otherwise indicated in this rule, when there is a month in which an employee is not in pay status for at least eight hours, the employee:

(a) Loses eligibility for the employer contribution for that month; and

(b) Must reestablish eligibility for PEBB benefits under WAC 182-12-114 in order to be eligible for the employer contribution again.

(7) **The employer contribution to PEBB insurance coverage ends** in any one of these circumstances for all employees:

(a) When the employee fails to maintain eligibility for the employer contribution as indicated in the criteria in subsection (1) through (6) of this section.

(b) When the employment relationship is terminated. As long as the employing agency has no anticipation that the employee will be rehired, the employment relationship is terminated:

(i) On the date specified in an employee's letter of resignation; or

(ii) On the date specified in any contract or hire letter or on the effective date of an employer-initiated termination notice.

(c) When the employee moves to a position that is not anticipated to be eligible for benefits under WAC 182-12-114, not including changes in position due to a layoff.

The employer contribution toward PEBB medical, dental and life insurance for ((~~a terminated~~)) an employee, spouse, ((~~qualified~~)) Washington state registered domestic partner, or child ceases at 12:00 midnight, the last day of the month in which the ((~~enrollee~~)) employee is eligible for the employer contribution under this rule. ((~~Basic long-term disability insurance ceases at 12:00 midnight the date employment ends or immediately upon the death of the employee.~~))

(8) **Options for continuation coverage by self-paying.** During temporary or permanent loss of the employer contribution toward insurance coverage, employees have options for providing continuation coverage for themselves and their dependents by self-paying the full premium set by the HCA. These options are available according to WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, and 182-12-270.

AMENDATORY SECTION (Amending Order 08-03, filed 10/1/08, effective 1/1/09)

WAC 182-12-133 What options for ((~~continuing~~)) continuation coverage are available to employees ((~~when they are no longer eligible for PEBB insurance coverage paid for by their employer~~)) on certain types of leave or whose work ends due to a layoff? ((~~Eligible~~)) Employees ((~~covered by PEBB insurance coverage~~)) who have established eligibility for PEBB benefits under WAC 182-12-114 have options for providing ((~~continued~~)) continuation coverage for themselves and their dependents by self-paying the full premium set by the HCA during temporary or permanent loss of ((~~eligibility~~)) the employer contribution toward insurance coverage. ((~~Except in the case of approved family and medical leave, and except as otherwise provided, only employees in pay status eight or more hours per month are eligible to receive the employer contribution.~~))

(1) When an employee is ((~~on leave without pay~~)) no longer eligible for the employer contribution toward PEBB benefits due to an event described in (a) through (f) of this subsection, insurance coverage may be continued ((~~at the group rate by self-paying premiums~~)) by self-paying the full premium set by the HCA, with no contribution from the employer. Employees may self-pay for a maximum of twenty-nine months. ((~~The number of months that an employee self-pays premium during a period of leave without pay will count toward the total months of continuation coverage allowed under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA).~~)) The employee must pay the premium amounts associated with insurance coverage as premiums become due. If premiums are more than sixty days delinquent, insurance coverage will end as of the last day of the month for which a full premium was paid. Employees may continue any combination of medical, dental and life insurance; however, only employees on approved educational leave may continue long-term disability insurance. Employ-

ees in the following ((~~types of leave~~)) circumstances qualify to continue coverage under this ((~~provision~~)) subsection:

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

(b) The employee is ((~~laid off because of a reduction in force (RIF)~~)) on approved educational leave;

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

(d) The employee is ((~~applying for disability retirement~~)) called to active duty in the uniformed services as defined under the Uniformed Services Employment and Reemployment Rights Act (USERRA);

(e) The ((~~employee is called to active duty in the uniformed services as defined under the Uniformed Services Employment and Reemployment Rights Act (USERRA)~~)) employee's employment ends due to a layoff as defined in WAC 182-12-109; or

(f) The employee is ((~~on approved educational leave~~)) applying for disability retirement.

(2) ((~~Part-time faculty and part-time academic employees may self-pay premium at the group rate between periods of eligibility for a maximum of eighteen months. These employees may continue any combination of medical, dental and life insurance.~~

~~(3)~~)) The number of months that an employee self-pays the premium while eligible under subsection (1) of this section will count toward the total months of continuation coverage allowed under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) ((~~gives enrollees the right to continue medical and dental for a period of eighteen to twenty-nine months when they lose eligibility due to one of the following qualifying events.~~

~~(a) Termination of employment.~~

~~(b) The employee's hours are reduced to the extent of losing eligibility.~~

~~(4) Employees who are approved for leave under the federal Family and Medical Leave Act (FMLA) are eligible to receive the employer contribution toward premium for up to twenty-six weeks, as provided in WAC 182-12-138~~)). An employee who is no longer eligible for continuation coverage as described in subsection (1) of this section but who has not used the maximum number of months allowed under COBRA may continue medical and dental for the remaining difference in months by self-paying the premium under COBRA as described in WAC 182-12-146.

AMENDATORY SECTION (Amending Order 07-01, filed 10/3/07, effective 11/3/07)

WAC 182-12-136 May an employee on approved educational leave waive ((~~PEBB health plan~~)) continuation coverage? In order to avoid duplication of group health plan coverage, the following shall apply to employees during any period of approved educational leave. Employees eligible for continuation coverage provided in WAC 182-12-133 who obtain comprehensive health plan coverage under another group plan may waive continuance of such coverage for each full calendar month in which they maintain coverage under the other comprehensive group health plan. These employees have the right to reenroll in a PEBB health plan effective the first day of the month after the date the other comprehensive group health plan coverage ends, provided evidence of such other comprehensive group health plan coverage is provided to the PEBB ((~~benefits services~~)) program upon application for reenrollment.

AMENDATORY SECTION (Amending Order 08-03, filed 10/1/08, effective 1/1/09)

WAC 182-12-138 What options are available if an employee is approved for ((~~family and medical leave, what insurance coverage may be continued~~)) the federal Family and Medical Leave Act (FMLA)? (1) Employees on approved leave under the federal Family and Medical Leave Act (FMLA) may continue to receive ((~~up to twenty-six weeks of~~)) the employer((~~paid medical, dental, basic life, and basic long-term disability insurance~~)) contribution toward insurance coverage in accordance with the federal FMLA. These employees may also continue current optional life and long-term disability. The employee's employing agency is responsible for determining if the employee is eligible for leave under FMLA and the duration of such leave. ((~~The employee must pay the premium amounts associated with insurance coverage monthly as premiums become due.~~)) If premiums are more than sixty days delinquent, insurance coverage will end as of the last day of the month for which a full premium ((~~is~~)) was paid.

(2) If an employee exhausts the period of leave approved under FMLA, insurance coverage may be continued by self-paying the full premium set by the HCA, with no contribution from the employer, under WAC 182-12-133(1) while on approved leave.

AMENDATORY SECTION (Amending Order 07-01, filed 10/3/07, effective 11/3/07)

WAC 182-12-141 If I revert from an eligible position to ((~~an ineligible~~)) another position, what happens to my insurance coverage? ((~~Employees who revert to a position that is ineligible~~)) (1) If you have reverted for reasons other than a layoff and are not eligible for the employer contribution toward insurance coverage under this chapter, you may continue ((~~enrollment in a~~)) PEBB ((~~health plan~~)) insurance coverage by self-paying the full premium set by the HCA for up to eighteen months (((~~and in some cases up to twenty-nine months~~))) under the same terms as an employee who is granted leave without pay under WAC 182-12-133(1).

(2) If you are reverted due to a layoff:

(a) You may be eligible for the employer contribution toward insurance coverage under the criteria of WAC 182-12-129; or

(b) You may continue PEBB insurance coverage by self-paying the full premium set by the HCA under WAC 182-12-133.

NEW SECTION

WAC 182-12-142 What options for continuation coverage are available to faculty and seasonal employees who are between periods of eligibility? (1) **Faculty** may continue any combination of medical, dental and life insurance coverage by self-paying the full premium set by the HCA,

with no contribution from the employer, for a maximum of twelve months between periods of eligibility. The employee must pay the premium amounts associated with insurance coverage as premiums become due. If premiums are more than sixty days delinquent, insurance coverage will end as of the last day of the month for which a full premium was paid.

(2) **Benefits-eligible seasonal employees** may continue any combination of medical, dental and life insurance coverage by self-paying the full premium set by the HCA, with no contribution from the employer, during their off-season(s). The employee must pay the premium amounts associated with insurance coverage as premiums become due. If premiums are more than sixty days delinquent, insurance coverage will end as of the last day of the month for which a full premium was paid.

(3) **COBRA.** An employee who is no longer eligible for continuation coverage as described in subsections (1) and (2) of this section, but who has not used the maximum number of months allowed under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), may continue medical and dental for the remaining difference in months by self-paying the full premium set by the HCA under COBRA as described in WAC 182-12-146. The number of months that a faculty or seasonal employee self-pays premiums under the criteria in subsection (1) or (2) of this section will count toward the total months of continuation coverage allowed under COBRA.

AMENDATORY SECTION (Amending Order 07-01, filed 10/3/07, effective 11/3/07)

WAC 182-12-146 ((~~Continuing health plan~~)) What options for continuation coverage are available to subscribers and dependents who become eligible under COBRA((~~,~~))? ((~~Enrollees~~)) (1) Employees and eligible dependents who become ineligible for the employer contribution toward PEBB insurance coverage and who qualify for ((~~continued~~)) continuation coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) may continue their medical and dental by ((~~self-payment of health plan premiums~~)) self-paying the full premium set by the HCA in accordance with COBRA statutes and regulations.

(2) An employee or an employee's dependent who is no longer eligible for continuation coverage as described in WAC 182-12-133, 182-12-138, 182-12-141, 182-12-142, or 182-12-148, but who has not used the maximum number of months allowed under COBRA, may continue medical and dental for the remaining difference in months by self-paying the premium under COBRA as described in subsection (1) of this section.

(3) Retired and disabled employees who become ineligible for PEBB retiree insurance because an employer group, with the exception of school districts and educational service districts, ceases participation in PEBB insurance coverage may continue their medical and dental by self-paying the full premium set by the HCA, in accordance with COBRA statutes and regulations.

AMENDATORY SECTION (Amending Order 07-01, filed 10/3/07, effective 11/3/07)

WAC 182-12-148 ((~~May an employee continue PEBB insurance~~)) What options for continuation coverage are available to employees during their appeal of dismissal? (1) Employees awaiting hearing of a dismissal action before any of the following may continue their insurance coverage by ((~~self-payment of~~)) self-paying the full premium set by the HCA, with no contribution from the employer, on the same terms as an employee who is granted leave ((~~without pay.~~)) as described in WAC 182-12-133:

(a) ((~~For an appeal filed on or before June 30, 2005, the personnel appeals board or any court.~~

~~(b) For an appeal filed on or after July 1, 2005,~~)) The personnel resources board((~~,~~));

(b) An arbitrator((~~,~~)); or

(c) A grievance or appeals committee established under a collective bargaining agreement for union represented employees.

(2) If the dismissal is upheld, all insurance coverage will end at the end of the month in which the decision is entered, or the date to which premiums have been paid, whichever is earlier, with the exception described in subsection (3) of this section.

(3)(((~~(a)~~))) If the dismissal is upheld and the employee is eligible under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), the employee may continue medical and dental for the remaining months available under COBRA. See WAC 182-12-146 for information on COBRA. The number of months the employee self-paid premiums during the appeal will count toward the total number of months allowed under COBRA.

(4) If the board, arbitrator, committee, or court sustains the employee in the appeal and directs reinstatement of employer paid insurance coverage retroactively, the ((~~employer~~)) employing agency must forward to HCA the full employer contribution for the period directed by the board, arbitrator, committee, or court and collect from the employee the employee's share of premiums due, if any.

(((~~(b)~~))) (a) HCA will refund to the employee any premiums the employee paid that may be provided for as a result of the reinstatement of the employer contribution only if the employee makes retroactive payment of any employee contribution amounts associated with the insurance coverage. In the alternative, at the request of the employee, HCA may deduct the employee's contribution from the refund of any premiums self-paid by the employee during the appeal period.

(((~~(c)~~))) (b) All optional life and long-term disability insurance which was in force at the time of dismissal shall be reinstated retroactively only if the employee makes retroactive payment of premium for any such optional coverage which was not continued by self-payment during the appeal process. If the employee chooses not to pay the retroactive premium, evidence of insurability will be required to restore such optional coverage.

AMENDATORY SECTION (Amending Order 08-03, filed 10/1/08, effective 1/1/09)

WAC 182-12-171 When are retiring employees eligible to enroll in retiree insurance? (1) **Procedural requirements.** Retiring employees must meet these procedural requirements, as well as have substantive eligibility under subsection (2) or (3) of this section.

(a) The employee must submit the appropriate forms to enroll or defer insurance coverage within sixty days after the employee's employer paid or COBRA coverage ends. The effective date of health plan enrollment will be the first day of the month following the loss of other coverage.

Exception: The effective dates of health plan enrollment for retirees who defer enrollment in a PEBB health plan at or after retirement are identified in WAC 182-12-200 and 182-12-205.

Employees who do not enroll in a PEBB health plan at retirement are only eligible to enroll at a later date if they have deferred enrollment as identified in WAC 182-12-200 or 182-12-205 and maintained comprehensive ((~~coverage~~)) employer sponsored medical as ((~~identified in WAC 182-12-200 or 182-12-205~~)) defined in WAC 182-12-109.

(b) The employee and enrolled dependents who are entitled to medicare must enroll and maintain enrollment in both medicare parts A and B if the employee retired after July 1, 1991. If the employee or an enrolled dependent becomes entitled to medicare after enrollment in PEBB retiree insurance, ((~~they~~)) he or she must enroll and maintain enrollment in medicare.

(2) **Eligibility requirements.** Eligible employees (as defined in WAC 182-12-115) who end public employment after becoming vested in a Washington state-sponsored retirement plan (as defined in subsection (4) of this section) are eligible to continue PEBB insurance coverage as a retiree if they meet procedural and eligibility requirements. To be eligible to continue PEBB insurance coverage as a retiree, the employee must be eligible to retire under a Washington state-sponsored retirement plan when the employee's employer paid or COBRA coverage ends.

Employees who do not meet their Washington state-sponsored retirement plan's age requirements when their employer paid or COBRA coverage ends, but who meet the age requirement within sixty days of coverage ending, may request that their eligibility be reviewed by the PEBB appeals committee to determine eligibility (see WAC 182-16-032). Employees must meet other retiree insurance election procedural requirements.

• Employees must immediately begin to receive a monthly retirement plan payment, with exceptions described below.

• Employees who receive a lump-sum payment instead of a monthly retirement plan payment are only eligible if this is required by department of retirement systems because their monthly retirement plan payment is below the minimum payment that can be paid.

• Employees who are members of a Plan 3 retirement, also called separated employees (defined in RCW 41.05.-011(13)), are eligible if they meet their retirement plan's age requirement and length of service when PEBB employee insurance coverage ends. They do not have to receive a retirement plan payment.

• Employees who are members of a Washington higher education retirement plan are eligible if they immediately begin to receive a monthly retirement plan payment, or meet their plan's age requirement, or are at least age fifty-five with ten years of state service.

• Employees who are permanently and totally disabled are eligible if they start receiving or defer a monthly disability retirement plan payment.

• Employees not retiring under a Washington state-sponsored retirement plan must meet the same age and years of service had the person been employed as a member of either public employees retirement system Plan 1 or Plan 2 for the same period of employment.

• Employees who retire from a local government or tribal government that participates in PEBB insurance coverage for their employees are eligible to continue PEBB insurance coverage as retirees if the employees meet the procedural and eligibility requirements under this section.

(a) **Local government employees.** If the local government ends participation in PEBB insurance coverage, employees who enrolled after September 15, 1991, are no longer eligible for PEBB retiree insurance. These employees may continue PEBB health plan enrollment under COBRA (see WAC 182-12-146).

(b) **Tribal government employees.** If a tribal government ends participation in PEBB insurance coverage, its employees are no longer eligible for PEBB retiree insurance. These employees may continue PEBB health plan enrollment under COBRA (see WAC 182-12-146).

(c) **Washington state K-12 school district and educational service district employees for districts that do not participate in PEBB benefits.** Employees of Washington state K-12 school districts and educational service districts who separate from employment after becoming vested in a Washington state-sponsored retirement system are eligible to enroll in PEBB health plans when retired or permanently and totally disabled.

Except for employees who are members of a retirement Plan 3, employees who separate on or after October 1, 1993, must immediately begin to receive a monthly retirement plan payment from a Washington state-sponsored retirement system. Employees who receive a lump-sum payment instead of a monthly retirement plan payment are only eligible if department of retirement systems requires this because their monthly retirement plan payment is below the minimum payment that can be paid or they enrolled before 1995.

Employees who are members of a Plan 3 retirement, also called separated employees (defined in RCW 41.05.011(13)), are eligible if they meet their retirement plan's age requirement and length of service when employer paid or COBRA coverage ends.

Employees who separate from employment due to total and permanent disability who are eligible for a deferred retirement allowance under a Washington state-sponsored retirement system (as defined in chapter 41.32, 41.35 or 41.40 RCW) are eligible if they enrolled before 1995 or within sixty days following retirement.

Employees who retired as of September 30, 1993, and began receiving a retirement allowance from a state-sponsored retirement system (as defined in chapter 41.32, 41.35 or 41.40 RCW) are eligible if they enrolled in a PEBB health plan not later than the HCA's annual open enrollment period for the year beginning January 1, 1995.

(3) **Elected ((~~state~~)) and full-time appointed officials of the legislative and executive branches.** Employees who are elected and full-time appointed state officials (as defined under WAC ((~~182-12-115(6)~~)) 182-12-114(4)) who voluntarily or involuntarily leave public office are eligible to continue PEBB insurance coverage as a retiree if they meet procedural and eligibility requirements. They do not have to receive a retirement plan payment from a state-sponsored retirement system.

(4) **Washington state-sponsored retirement systems include:**

- Higher education retirement plans;
- Law enforcement officers' and firefighters' retirement system;
- Public employees' retirement system;
- Public safety employees' retirement system;
- School employees' retirement system;
- State judges/judicial retirement system;
- Teacher's retirement system; and
- State patrol retirement system.

The two federal retirement systems, Civil Service Retirement System and Federal Employees' Retirement System, are considered a Washington state-sponsored retirement system for Washington State University Extension employees covered under the PEBB insurance coverage at the time of retirement or disability.

AMENDATORY SECTION (Amending Order 08-03, filed 10/1/08, effective 1/1/09)

WAC 182-12-175 May a local government entity or tribal government entity applying for participation in PEBB insurance coverage include their retirees in the transfer unit? Local government or tribal government entities applying for participation in PEBB insurance coverage under WAC 182-12-111 ((~~(4) and (6)~~)) (2), may request inclusion of retired employees who are covered under their retiree health plan at the time of application. The PEBB ((~~benefits services~~)) program will use the following criteria for approval of these requests for inclusion of retirees.

(1) The local government or tribal government retiree health plan must have existed at least three years before the date of application for participation in PEBB health plans.

(2) Eligibility for coverage under the local government's or tribal government's retiree health plan must have required immediate enrollment in retiree health plan coverage upon termination of employee coverage.

(3) The retiree must have maintained continuous enrollment in their local government or tribal government retiree health plan.

(4) To protect the integrity of the risk pool, if total local government or tribal government retiree enrollment exceeds ten percent of the total PEBB retiree population, the PEBB ((~~benefits services~~)) program may:

(a) Stop approving inclusion of retirees with local government or tribal government unit transfers; or

(b) May adopt a new rating methodology reflective of the cost of covering local government or tribal government retirees.

(5) Retirees and dependents included in the transfer unit are subject to the enrollment and eligibility rules outlined in chapters 182-08, 182-12 and 182-16 WAC.

(6) Employees eligible for retirement subsequent to the local government or tribal government transferring to PEBB health plan coverage must meet retiree eligibility as outlined in chapter 182-12 WAC.

AMENDATORY SECTION (Amending Order 08-03, filed 10/1/08, effective 1/1/09)

WAC 182-12-200 May a retiree who is enrolled as a dependent in a PEBB health plan or a Washington state K-12 school district sponsored health plan defer enrollment in a PEBB retiree health plan? Retirees who are enrolled in a PEBB or Washington state K-12 school district sponsored medical plan as a dependent may defer enrollment in a PEBB retiree health plan. Retirees who defer enrollment in medical cannot remain enrolled in dental. Retirees who defer may later enroll themselves and their dependents in PEBB retiree medical, or medical and dental, if they provide evidence of continuous enrollment in a PEBB or K-12 school district sponsored medical plan. Continuous enrollment must be from the date the retiree deferred enrollment in retiree insurance. Retirees may enroll:

(1) During any PEBB annual open enrollment period. (Enrollment in the PEBB health plan will begin ((~~the first day of~~)) January 1st after the annual open enrollment period.); or

(2) No later than sixty days after enrollment in the PEBB or K-12 school district sponsored medical plan ends. (Enrollment in the PEBB health plan will begin the first day of the month after the PEBB or K-12 school district health plan ends.)

AMENDATORY SECTION (Amending Order 08-03, filed 10/1/08, effective 1/1/09)

WAC 182-12-205 May a retiree defer enrollment in a PEBB health plan at or after retirement? Except as stated in subsection (1)(c) of this section and for adult dependents as defined in WAC 182-12-260 ((~~(4)~~))(3)(d), if retirees defer enrollment in a PEBB health plan, they also defer enrollment for all eligible dependents. Retirees may not defer their retiree term life insurance, even if they have other life insurance.

(1) Retirees may defer enrollment in a PEBB health plan at or after retirement if continuously enrolled in other comprehensive employer sponsored medical as identified below:

(a) Beginning January 1, 2001, retirees may defer enrollment if they are enrolled in comprehensive employer-sponsored medical as an employee or the dependent of an employee.

(b) Beginning January 1, 2001, retirees may defer enrollment if they are enrolled in medical as a retiree or the dependent of a retiree enrolled in a federal retiree plan.

(c) Beginning January 1, 2006, retirees may defer enrollment if they are 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 health plan enrollment if they meet PEBB eligibility criteria and are not eligible for creditable coverage under a medicaid program.

(2) To defer health plan enrollment, the retiree must submit the appropriate forms to the PEBB ((~~benefits services~~)) program requesting to defer. The PEBB ((~~benefits services~~)) program must receive the form before health plan enrollment is deferred or no later than sixty days after the date the retiree becomes eligible to apply for PEBB retiree insurance coverage.

(3) Retirees who defer may enroll in a PEBB health plan as follows:

(a) Retirees who defer while enrolled in comprehensive employer-sponsored medical may enroll in a PEBB health plan by submitting the appropriate forms and evidence of continuous enrollment in comprehensive employer-sponsored medical to the PEBB ((~~benefits services~~)) program:

(i) During annual open enrollment. (((~~Enrollment in the~~)) PEBB health plan will begin ((~~the first day of~~)) January 1st after the annual open enrollment.); or

(ii) No later than sixty days after their comprehensive employer-sponsored medical ends. (((~~Enrollment in the~~)) PEBB health plan will begin the first day of the month after the comprehensive employer-sponsored medical ends.)

(b) Retirees who defer enrollment while enrolled as a retiree or dependent of a retiree in a federal retiree medical plan will have a one-time opportunity to enroll in a PEBB health plan by submitting the appropriate forms and evidence of continuous enrollment in a federal retiree medical plan to the PEBB ((~~benefits services~~)) program:

(i) During annual open enrollment. (((~~Enrollment in the~~)) PEBB health plan will begin ((~~the first day of~~)) January 1st after the annual open enrollment.); or

(ii) No later than sixty days after the federal retiree medical ends. (Enrollment in the PEBB health plan will begin the first day of the month after the federal retiree medical ends.)

(c) Retirees who defer enrollment while enrolled in medicare Parts A and B and medicaid may enroll in a PEBB health plan by submitting the appropriate forms and evidence of continuous enrollment in creditable coverage to the PEBB ((~~benefits services~~)) program:

(i) During annual open enrollment. (Enrollment in the PEBB health plan will begin ((~~the first day of~~)) January 1st after the annual open enrollment.); or

(ii) No later than sixty days after their medicaid coverage ends (Enrollment in the PEBB health plan will begin the first day of the month after the medicaid coverage ends.); or

(iii) No later than the end of the calendar year when 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. (Enrollment in the PEBB health plan will begin ((~~the first day of~~)) January 1st following the end of the calendar year when the medicaid coverage ends.)

(d) Retirees who defer enrollment may enroll in a PEBB health plan if the retiree receives formal notice that the department of social and health services has determined it is more cost-effective to enroll the retiree or the retiree's eligible dependent(s) in PEBB medical than a medical assistance program.

AMENDATORY SECTION (Amending Order 07-01, filed 10/3/07, effective 11/3/07)

WAC 182-12-207 When can a retiree or eligible dependent's insurance coverage be canceled by HCA? A retiree or eligible dependent's insurance coverage can be canceled by HCA for the following reasons:

(1) Failure to comply with the PEBB program's procedural requirements, including failure to provide information or documentation requested by the due date ((~~or~~)) in written requests from the PEBB program;

(2) Knowingly providing false information((~~.~~));

(((~~(2)~~))) (3) Failure to pay the premium when due or an underpayment of premium((~~.~~));

(((~~(3)~~))) (4) Misconduct. If a retiree's insurance coverage is canceled for misconduct, insurance coverage will not be reinstated at a later date. Examples of such termination include, but are not limited to the following:

(a) Fraud, intentional misrepresentation or withholding of information the subscriber knew or should have known was material or necessary to accurately determine eligibility or the correct premium; or

(b) Abusive or threatening conduct repeatedly directed to an HCA employee, a health plan or other HCA contracted vendor providing insurance coverage on behalf of the HCA, its employees, or other persons.

If a retiree's insurance coverage is canceled by HCA for the above reasons, insurance coverage for all of the retiree's eligible dependents is also canceled.

AMENDATORY SECTION (Amending Order 07-01, filed 10/3/07, effective 11/3/07)

WAC 182-12-208 May a retiree enroll only in dental? If an enrollee is enrolled in retiree insurance coverage, ((~~they~~)) he or she may not enroll in dental unless ((~~they~~)) he or she is also ((~~enroll~~)) enrolled in medical.

AMENDATORY SECTION (Amending Order 08-03, filed 10/1/08, effective 1/1/09)

WAC 182-12-209 Who is eligible for retiree life insurance? Eligible employees who participate in PEBB life insurance as an employee and meet qualifications for retiree insurance coverage as provided in WAC 182-12-171 are eligible for PEBB retiree life insurance. They must submit the appropriate forms to the PEBB ((~~benefits services~~)) program no later than sixty days after the date their PEBB employee life insurance ends. ((~~However,~~))

(1) Employees whose life insurance premiums are being waived under the terms of the life insurance contract are not eligible for retiree term life insurance until their waiver of premium benefit ends.

(2) Retirees may not defer enrollment in retiree term life insurance.

(3) If a retiree returns to active employee status in an employing agency, he or she must continue to self-pay retiree

life insurance premiums in order to maintain retiree term life insurance (even while participating in PEBB employee life insurance).

AMENDATORY SECTION (Amending Order 07-01, filed 10/3/07, effective 11/3/07)

WAC 182-12-211 If department of retirement systems makes a formal determination of retroactive eligibility, may the retiree enroll in PEBB retiree insurance coverage? (1) When the Washington state department of retirement systems (DRS) makes a formal determination that a person is retroactively eligible for pension benefits that person may apply for enrollment in a PEBB health plan only if application is made within sixty days after the date of notice from DRS.

(2) All premiums due from the date of eligibility established by DRS or the date of the DRS decision letter, at the option of the retiree, must be sent with the application to the PEBB ((~~benefits services~~)) program.

(3) The administrator may make an exception to the date PEBB retiree insurance coverage commences or payment of premiums; however, such requests must demonstrate extraordinary circumstances beyond the control of the retiree.

AMENDATORY SECTION (Amending Order 08-03, filed 10/1/08, effective 1/1/09)

WAC 182-12-250 Insurance coverage eligibility for survivors of emergency service personnel killed in the line of duty. Surviving spouses, Washington state registered domestic partners, and dependent children of emergency service personnel who are killed in the line of duty are eligible to enroll in health plans administered by the PEBB ((~~benefits services~~)) program within HCA.

(1) This section applies to the surviving spouse, the surviving Washington state registered domestic partner, and dependent children of emergency service personnel "killed in the line of duty" as determined by the Washington state department of labor and industries.

(2) "Emergency service personnel" means law enforcement officers and firefighters as defined in RCW 41.26.030, members of the Washington state patrol retirement fund as defined in RCW 43.43.120, and reserve officers and firefighters as defined in RCW 41.24.010.

(3) "Surviving spouse, Washington state registered domestic partner, and dependent children" means:

(a) A lawful spouse;

(b) An ex-spouse as defined in RCW 41.26.162;

(c) A Washington state registered domestic partner as defined in RCW 26.60.020; and

(d) Children. The term "children" includes unmarried children of the emergency service worker who are under the age of twenty-five. Children with disabilities as defined in RCW 41.26.030(7) are eligible at any age. "Children" is defined as:

(i) Biological children (including the emergency service worker's posthumous children);

(ii) Stepchildren or children of a Washington state registered domestic partner; and

(iii) Legally adopted children.

(4) Surviving spouses, Washington state registered domestic partners, and children who are entitled to medicare must enroll in both parts A and B of medicare.

(5) The survivor (or agent acting on their behalf) must submit the appropriate forms (to either enroll or defer enrollment in a PEBB health plan) to PEBB ((~~benefits services~~)) program no later than one hundred eighty days after the latter of:

(a) The death of the emergency service worker;

(b) The date on the letter from the department of retirement systems or the board for volunteer firefighters and reserve officers that informs the survivor that he or she is determined to be an eligible survivor;

(c) The last day the surviving spouse, Washington state registered domestic partner, or child was covered under any health plan through the emergency service worker's employer; or

(d) The last day the surviving spouse, Washington state registered domestic partner, or child was covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage from the emergency service worker's employer.

(6) Survivors who do not choose to defer enrollment in a PEBB health plan may choose among the following options for when their enrollment in a PEBB health plan will begin:

(a) June 1, 2006, for survivors whose appropriate forms are received by the PEBB ((~~benefits services~~)) program no later than September 1, 2006;

(b) The first of the month that is not earlier than sixty days before the date that the PEBB ((~~benefits services~~)) program receives the appropriate forms (for example, if the PEBB ((~~benefits services~~)) program receives the appropriate forms on August 29, the survivor may request health plan enrollment to begin on July 1); or

(c) The first of the month after the date that the PEBB ((~~benefits services~~)) program receives the appropriate forms.

For surviving spouses, Washington state registered domestic partners, and children who enroll, monthly health plan premiums must be paid by the survivor except as provided in RCW 41.26.510(5) and 43.43.285 (2)(b). For children age twenty through age twenty-four who enroll and are not students under the age of twenty-four attending high school or registered at an accredited secondary school, college, university, vocational school, or school of nursing: The adult dependent premium must be paid by the survivor except as provided in RCW 41.26.510(5) and 43.43.285 (2)(b).

(7) Survivors must choose one of the following two options to maintain eligibility for PEBB insurance coverage:

(a) Enroll in a PEBB health plan:

(i) Enroll in medical; or

(ii) Enroll in medical and dental.

(iii) Survivors enrolling in dental must stay enrolled in dental for at least two years before dental can be dropped.

(iv) Dental only is not an option.

(b) Defer enrollment:

(i) Survivors may defer enrollment in a PEBB health plan if enrolled in comprehensive employer sponsored medical ((~~coverage through an employer~~)).

(ii) Survivors may enroll in a PEBB health plan when they lose comprehensive employer sponsored medical ((~~coverage~~)). Survivors will need to provide evidence that they

were continuously enrolled in comprehensive employer sponsored medical ((~~coverage through an employer~~)) when applying for a PEBB health plan, and apply within sixty days after the date their other coverage ended.

(iii) PEBB health plan enrollment and premiums will begin the first day of the month following the day that the other coverage ended for eligible spouses and children who enroll.

(8) Survivors may change their health plan during annual open enrollment. In addition to annual open enrollment, survivors may change health plans as described in WAC 182-08-198.

(9) Survivors may not add new dependents acquired through birth, marriage, or establishment of a qualified domestic partnership.

(10) Survivors will lose their right to enroll in a PEBB health plan if they:

(a) Do not apply to enroll or defer PEBB health plan enrollment within the timelines stated in subsection (5) of this section; or

(b) Do not maintain continuous enrollment in comprehensive employer sponsored medical ((~~coverage~~)) through an employer during the deferral period, as provided in subsection (7)(b)(i) of this section.

AMENDATORY SECTION (Amending Order 08-03, filed 10/1/08, effective 1/1/09)

WAC 182-12-260 Who are eligible dependents? To be enrolled in a health plan, a dependent must be eligible under this section and the subscriber must comply with enrollment procedures outlined in WAC 182-12-262.

The PEBB program verifies the eligibility of all dependents periodically and reserves the right to request documents from subscribers that provide evidence of a dependent's eligibility. The PEBB program will remove a subscriber's enrolled dependents from health plan enrollment if the PEBB program is unable to verify a dependent's eligibility within a specified time.

The subscriber or dependent must notify the PEBB program, in writing, no later than sixty days after the date he or she is no longer eligible under this section. See WAC 182-12-262 for the consequences of not removing an ineligible dependent from coverage.

The following are eligible as dependents under the PEBB eligibility rules:

(1) Lawful spouse. Former spouses are not eligible dependents upon finalization of a divorce or annulment, even if a court order requires the subscriber to provide health insurance for the former spouse.

(2) ((~~Domestic partner qualified by the PEBB declaration of domestic partnership that meets all of the following criteria:~~

~~(a) Partners have a close personal relationship in lieu of a lawful marriage;~~

~~(b) Partners are not married to anyone;~~

~~(c) Partners are each other's sole domestic partner and are responsible for each other's common welfare;~~

~~(d) Partners are not related by blood as close as would bar marriage; and~~

~~(e) Partners are barred from a lawful marriage in Washington state.~~

~~(3) Domestic partner qualified by the certificate of~~)) Effective January 1, 2010, Washington state registered domestic ((~~partnership or registration card issued by the Washington secretary of state for a same-sex partnership~~)) partners, as defined in RCW 26.60.020(1). Former Washington state registered domestic partners are not eligible dependents upon dissolution or termination of a partnership, even if a court order requires the subscriber to provide health insurance for the former partner.

(((~~(4)~~))) (3) Children. Children are defined as the subscriber's biological children, stepchildren, legally adopted children, children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child, children of the subscriber's ((~~qualified~~)) Washington state registered domestic partner, or children specified in a court order or divorce decree. In addition, children include extended dependents in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or subscriber's ((~~qualified~~)) Washington state registered domestic partner. The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. "Children" does not include foster children for whom support payments are made to the subscriber through the state department of social and health services foster care program.

Eligible children include:

(a) Unmarried children through age nineteen.

(b) Married children through age nineteen who qualify as dependents of the subscriber under the Internal Revenue Code.

(c) Students: Unmarried children age twenty through age twenty-three who are attending high school or are registered students at an accredited secondary school, college, university, vocational school, or school of nursing (((~~students~~))). A married child is eligible as a student if the child is a dependent of the subscriber under the Internal Revenue Code.

(i) A child is eligible as a student or can maintain eligibility as a student when not registered for courses through the summer or off quarter/semester as long as the child meets all other eligibility requirements and is in any one of the following circumstances:

• The child attended the three consecutive quarters or two consecutive semesters before the off quarter/semester.

((~~• The child is an enrolled dependent turning age twenty or renewing annual student certification and the child is expected to register for three consecutive quarters or two consecutive semesters after the off quarter/semester.~~))

• The child recently graduated. Graduation is defined as the successful completion of studies to earn a degree or certificate, not the date of the graduation ceremony. The child is eligible for the three month period following graduation.

(ii) For student dependents who are not eligible for the summer or off quarter/semester according to (c)(i) of this subsection, student eligibility begins the first day of the month of the quarter or semester for which the child is registered, and eligibility ends the last day of the month in which the student ((~~stops attending~~)) is registered or in which the quarter or semester ends, whichever is first.

((~~The PEBB benefits services program certifies students annually. Health plan enrollment ends the last day of the month in which certification ends or the student ceases to meet eligibility criteria, whichever comes first. See WAC 182-12-262 (3)(g) and (7) for enrollment requirements.~~))

Exception: If a student becomes seriously ill or injured and requires a medically necessary leave of absence from attending school, his or her coverage may continue if qualified under and in accordance with the federal Michelle's Law (Public Law 110-381).

(d) Adult dependents: Unmarried children age twenty through age twenty-four (((~~adult dependents~~))).

Subscriber must pay the adult dependent premium for adult dependents whom the subscriber has enrolled. ((~~Nonpayment of premium will result in termination of coverage back to the end of the month for which the last full month premium was paid.~~))

Adult dependents must enroll in the same health plan as the subscriber.

Exception: The adult dependent may enroll in a different health plan than the subscriber if the dependent does not reside within the subscriber's plan service area or the subscriber has waived or deferred medical.

(e) Children of any age with disabilities, developmental disabilities, mental illness or mental retardation who are incapable of self-support, provided such condition occurs before age twenty or during the time the dependent was eligible as a student under (c) of this subsection.

The subscriber must provide evidence that such disability occurred as stated below:

(i) For a child enrolled in PEBB insurance coverage, the subscriber must provide evidence of the disability within sixty days of the child's attainment of age twenty.

(ii) For a child enrolled in PEBB insurance coverage as a student under (c) of this subsection, the subscriber must provide evidence of the disability within sixty days after the student is no longer eligible under (c) of this subsection.

(iii) For a child, age twenty or older, who is a new dependent or for a child, age twenty or older, who is a dependent of a newly eligible subscriber, the child may be enrolled as a dependent child with disabilities if the subscriber provides evidence that the condition occurred before the child reached age twenty or evidence that when the condition occurred the child would have satisfied PEBB eligibility for student coverage under (c) of this subsection had the subscriber been eligible for PEBB benefits at the time.

The subscriber must notify the PEBB ((~~benefits services~~)) program, in writing, no later than sixty days after the date that a child age twenty or older no longer qualifies under this subsection.

For example, children who become self-supporting are not eligible under this rule as of the last day of the month in which they become capable of self-support. The child may be eligible to continue enrollment as an adult dependent, as per (d) of this subsection, or in a PEBB health plan under provisions of WAC 182-12-270.

Children age twenty and older who become capable of self-support do not regain eligibility under (e) of this subsection if they later become incapable of self-support.

The PEBB ((~~benefits services~~)) program will ((~~recertify~~)) certify the eligibility of children with disabilities periodically.

(((~~5~~))) (4) Parents.

(a) Parents covered under PEBB medical before July 1, 1990, may continue enrollment on a self-pay basis as long as:

(i) The parent maintains continuous enrollment in PEBB medical;

(ii) The parent qualifies under the Internal Revenue Code as a dependent of the subscriber;

(iii) The subscriber continues enrollment in PEBB insurance coverage; and

(iv) The parent is not covered by any other group medical plan.

(b) Parents eligible under this subsection may be enrolled with a different health plan than that selected by the subscriber. Parents may not add additional dependents to their insurance coverage.

((~~(6) The enrollee (or the subscriber on their behalf) must notify the PEBB benefits services program, in writing, no later than sixty days after the date they are no longer eligible under this section. A PEBB continuation of coverage election notice and continued health plan enrollment will only be available if the PEBB benefits services program is notified in writing within the sixty-day period.~~))

AMENDATORY SECTION (Amending Order 08-03, filed 10/1/08, effective 1/1/09)

WAC 182-12-262 When may subscribers enroll((~~, waive~~)) or remove eligible dependents? (1) **Enrolling dependents in health plan coverage.** Subscribers may enroll ((~~or waive~~)) eligible dependents at the following times:

(a) **When the subscriber becomes eligible** and enrolls in PEBB insurance coverage. If enrolled, the dependent's effective date will be the same as the subscriber's effective date. ((~~Unless a dependent is independently eligible for PEBB health plan coverage,~~)) The subscriber must be enrolled to enroll ((~~their~~)) his or her dependent.

Exceptions:
- Adult dependents may enroll in a health plan if the employee has waived medical coverage or the retiree has deferred enrollment in PEBB retiree insurance in accordance with PEBB rule;

OR

- Eligible dependents of a retiree may enroll in a health plan if the retiree deferred PEBB retiree insurance coverage due to the retiree's enrollment in medicare and creditable medicaid under WAC 182-12-205 (1)(c).

((~~(2) **Subscribers may enroll eligible dependents**~~))

(b) **During the annual open enrollment** ((~~with~~)), PEBB health plan coverage ((~~beginning~~)) begins January 1st of the following year.

((~~(3) **Subscribers may enroll a newly acquired dependent or a dependent that becomes eligible during a special open enrollment.**~~

~~(a) A spouse may be enrolled upon marriage. If the date of marriage is the first day of the month, health plan coverage will begin on that date; otherwise, it will begin the first of the following month.~~

~~(b) A qualified domestic partner may be enrolled upon declaration or registration of the domestic partnership (see WAC 182-12-260). If the date of declaration or registration is the first day of the month, health plan coverage will begin on that date; otherwise, it will begin the first of the following month.~~

~~(c) Newborn children may be enrolled upon birth and adopted children may be enrolled when the subscriber assumes legal responsibility for the child in anticipation of adoption. The child's health plan coverage will begin on the date of birth or the date the subscriber assumes legal responsibility for the child in anticipation of adoption. The subscriber must submit the appropriate forms as described in subsection (7) of this section no later than sixty days after birth or assuming legal responsibility for the child.~~

~~(d) Children acquired through marriage or a qualified domestic partnership may be enrolled upon marriage or declaration or registration of the domestic partnership as described in (a) or (b) of this subsection.~~

~~(e) Extended dependents acquired through legal guardianship or legal custody (see WAC 182-12-260(4)) may be enrolled upon issuance of a court order granting such responsibility to the subscriber, spouse, or qualified domestic partner. If legal guardianship or legal custody begins on the first day of the month, health plan coverage will begin on that date; otherwise, it will begin the first of the following month.~~

~~(f) Children age twenty through age twenty-four (adult dependents) may be enrolled when they become eligible (see WAC 182-12-260 (4)(d)). If they become eligible on the first day of the month, health plan coverage will begin on that date; otherwise, it will begin the first of the month following the date they become eligible. For enrollment requirements, see subsection (7) of this section.~~

~~(g) Children who become eligible as students may be enrolled provided the child's eligibility is certified by the PEBB benefits services program. If enrolled, the child's insurance coverage will begin or continue on the first day of the month the child becomes eligible as a student according to WAC 182-12-260 (4)(c).~~

~~(h) A child twenty years or older who becomes eligible as a child with disabilities under WAC 182-12-260 (4)(c) may be enrolled after the child's eligibility is certified by the PEBB benefits services program.~~

~~Health plan coverage will begin on the first day of the month that eligibility is certified by the PEBB benefits services program.~~

~~(4)~~)) (c) **During special open enrollment.** Subscribers may enroll dependents when the dependent becomes eligible or during another special open enrollment as described in subsections (3) and (4) of this section.

(2) **Removing dependents from a subscriber's health plan coverage.**

(a) **Subscribers are required to remove dependents** within sixty days of the date the dependent no longer meets the eligibility criteria in WAC 182-12-250 or 182-12-260. The PEBB program will remove a subscriber's enrolled dependent the last day of the month in which the dependent ceases to meet the eligibility criteria. Consequences for not submitting notice within sixty days of any dependent ceasing to be eligible may include, but are not limited to:

(i) The dependent may lose eligibility to continue health plan coverage under one of the continuation coverage options described in WAC 182-12-270;

(ii) The subscriber may be billed for claims paid by the health plan for services after the dependent lost eligibility;

(iii) The subscriber may not be able to recover subscriber-paid insurance premiums that included dependents that lost their eligibility; and

(iv) The subscriber may be responsible for premiums paid by the state for the dependent's health plan coverage after the dependent lost eligibility.

(b) **Employees have the opportunity to remove dependents:**

(i) During the annual open enrollment. The dependent will be removed the last day of December; or

(ii) During a special open enrollment as described in subsection (3) of this section. The dependent will be removed the last day of the month following the date corresponding to the event that creates the special open enrollment.

(c) **Retirees, survivors, and enrollees with PEBB continuation coverage under WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, or 182-12-148 may remove dependents** from their coverage outside of the annual open enrollment or a special open enrollment by providing written notice to the PEBB program. Unless otherwise approved by the PEBB program, the dependent will be removed from the subscriber's coverage prospectively.

(3) **Special open enrollment.** Subscribers may ((~~change the enrollment (~~))enroll((~~, waive~~)) or remove((~~) of~~)) their dependents outside of the annual open enrollment if a special open enrollment event occurs. The change in enrollment must correspond to the event that creates the special open enrollment for either the subscriber or the subscriber's dependents or both. ((~~Enrollment in~~))

• Health plan coverage will begin the first of the month following the event that created the special open enrollment; or in cases where the event occurs on the first day of a month, ((~~enrollment~~)) health plan coverage will begin on that date.

• Dependents will be removed from the subscriber's health plan coverage the last day of the month following the event.

• If the special open enrollment is due to the birth or adoption or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of a child, health plan coverage will begin or end the month in which the event occurs. The following changes are events that create a special open enrollment for medical and dental:

(a) Subscriber acquires an eligible dependent through marriage, registering a domestic partnership with Washington state, birth, adoption or ((~~placement for~~)) when a subscriber has assumed a legal obligation for total or partial support in anticipation of adoption, legal custody or legal guardianship;

(b) A dependent becomes eligible by fulfilling PEBB dependent eligibility criteria under WAC 182-12-250 or 182-12-260;

(c) Subscriber loses an eligible dependent or a dependent no longer meets PEBB eligibility criteria;

(((~~(c)~~))) (d) Subscriber has a change in marital status or Washington state registered domestic partnership status, including legal separation documented by a court order;

(((~~(d)~~))) (e) Subscriber or a dependent loses comprehensive group health insurance coverage;

(((~~(e)~~))) (f) Subscriber or a dependent has a change in employment status that affects the subscriber's or a dependent's eligibility, level of benefits, or cost of insurance coverage;

(((~~(f)~~))) (g) Subscriber or a dependent has a change in place of residence that affects the subscriber's or a dependent's eligibility, level of benefits, or cost of insurance coverage;

(((~~(g)~~))) (h) Subscriber receives a court order or medical support enforcement order requiring the subscriber, their spouse, or ((~~qualified~~)) Washington state registered domestic partner to provide insurance coverage for an eligible dependent. (A former spouse or former registered domestic partner is not an eligible dependent.);

(((~~(h)~~))) (i) Subscriber ((~~receives formal notice that~~)) or dependent becomes eligible for a medical assistance program under the department of social and health services ((~~has determined it is more cost-effective to enroll an eligible dependent in PEBB medical than~~)), including medicaid or the children's health insurance program (CHIP), or the subscriber or dependent loses eligibility in such a medical assistance program((~~.~~

~~(5) **Subscribers may waive (interrupt or postpone) enrollment of an eligible dependent.**~~

~~(a) Employees may only waive dependents if those dependents are enrolled in another comprehensive group health plan. Employees may only waive an eligible dependent's enrollment at the following times:~~

~~(i) When the employee is first eligible and enrolls in PEBB benefits. (The dependent's enrollment will be waived beginning with the employee's effective date.);~~

~~(ii) During the annual open enrollment. (The dependent's enrollment will be waived beginning January of the following year.);~~

~~(iii) No later than sixty days after the dependent becomes eligible as described in subsection (3) of this section. (The dependent's enrollment will be waived beginning the date enrollment would have begun.); or~~

~~(iv) During a special open enrollment as described in subsection (4) of this section. (The dependent's enrollment will be waived as of the date corresponding to the event that creates the special open enrollment.)~~

~~(b) Retirees, survivors or individuals continuing PEBB insurance coverage under WAC 182-12-133 or 182-12-270 may waive enrollment of an eligible dependent outside of the annual open enrollment or a special open enrollment. Unless otherwise approved by the PEBB benefits services program, enrollment will be waived prospectively.~~

~~(c) Subscribers may enroll eligible dependents that were waived as stated in subsections (2) and (4) of this section.~~

~~(6) **Subscribers must remove dependents from the subscriber's insurance coverage within sixty days of the date the dependent no longer meets eligibility criteria** in WAC 182-12-250 or 182-12-260. Insurance coverage enrollment ends the last day of the month in which the dependent is eligible.~~

~~Subscribers may remove a lawful spouse from PEBB insurance coverage in the event of legal separation documented by a court order, provided the court did not order the subscriber to maintain the spouse's health plan enrollment. Subscribers must remove former spouses and former qualified domestic partners upon finalization of a divorce, annulment, or termination of a partnership, even if a court order requires the subscriber to provide health insurance for the former spouse or partner.~~

~~Consequences for not submitting notice as described in subsection (7) of this section within sixty days of any dependent ceasing to be eligible may include:~~

~~(a) The dependent's loss of eligibility to continue health plan enrollment under one of the continuation options described in WAC 182-12-270;~~

~~(b) The subscriber being billed for claims paid by the health plan for services after the dependent lost eligibility; and~~

~~(c) The subscriber being responsible for premiums paid by the state for the dependent's health plan enrollment after the dependent lost eligibility.~~

~~(7)~~))); or

(j) Subscriber or dependent dies.

(4) **Enrollment requirements. Subscribers must submit the appropriate forms within the time frames described in this subsection.** Employees submit the appropriate forms to their employing agency. All other subscribers submit the appropriate forms to the PEBB ((~~benefits services~~)) program. In addition to the appropriate forms indicating dependent enrollment, the PEBB ((~~benefits services~~)) program may require the subscriber to provide documentation or evidence of eligibility or evidence of the event that created the special open enrollment.

(a) If a subscriber wants to enroll their eligible dependent(s) when the subscriber becomes eligible to enroll in PEBB benefits, the subscriber must include the dependent's enrollment information on the appropriate forms that the subscriber submits within the relevant time frame described in WAC 182-08-197, 182-12-171, or 182-12-250.

(b) If a subscriber wants to enroll eligible dependents during the annual open enrollment, the subscriber must submit the appropriate forms no later than the end of the annual open enrollment.

(c) If a subscriber wants to enroll newly eligible dependents, the subscriber must submit the appropriate enrollment forms no later than sixty days after the dependent becomes eligible except as provided in (d) of this subsection.

(d) If a subscriber wants to enroll a newborn or child whom the subscriber has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption, the subscriber should notify the PEBB program by submitting an enrollment form as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the subscriber **must** submit the appropriate enrollment form no later than twelve months after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption.

(e) If the subscriber wants to enroll a child age twenty or older as a child with disabilities, the subscriber must submit the appropriate enrollment form(s) required to certify the dependent's eligibility within the relevant time frame described in WAC 182-12-250(3) or 182-12-260((~~(4)~~)) (3).

((~~(e)~~)) (f) If the subscriber wants to change a dependent's enrollment status during a special open enrollment, the subscriber must submit the appropriate forms no later than sixty days after the event that creates the special open enrollment.

((~~(f)~~)) (g) If the subscriber wants to ((~~waive~~)) remove a ((~~dependent's~~)) dependent from enrollment during an open enrollment, the subscriber must submit the appropriate forms. Unless otherwise approved by the PEBB ((~~benefits services~~)) program, enrollment will be ((~~waived~~)) removed prospectively.

AMENDATORY SECTION (Amending Order 08-03, filed 10/1/08, effective 1/1/09)

WAC 182-12-265 What options for continuing health plan enrollment 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 insurance coverage as a surviving dependent. An eligible surviving spouse, ((~~qualified~~)) Washington state registered domestic partner, or child must enroll in or defer enrollment in a PEBB medical plan no later than sixty days after the date of the employee's or retiree's death.

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

(a) The employee's spouse or ((~~qualified~~)) Washington state registered domestic partner may continue health plan enrollment until death.

(b) Children may continue health plan enrollment until they lose eligibility under PEBB rules.

(c) If a surviving spouse, ((~~qualified~~)) Washington state registered domestic partner, or child 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 for PEBB retiree insurance as a survivor. However, the dependent may continue health plan enrollment 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 who lose eligibility due to the death of a PEBB eligible retiree may continue health plan enrollment under retiree insurance.

(a) The retiree's spouse or ((~~qualified~~)) Washington state registered domestic partner may continue health plan enrollment until death.

(b) Children may continue health plan enrollment until they lose eligibility under PEBB rules.

(c) Dependents, ((~~whose enrollment~~)) who are not enrolled in a PEBB health plan ((~~is waived~~)) at the time of the retiree's death, are eligible to enroll or defer enrollment in PEBB retiree insurance. A form to enroll or defer PEBB health plan enrollment must be hand-delivered or mailed to the PEBB ((~~benefits services~~)) program no later than sixty days after the retiree's death. To enroll in a PEBB health plan, the dependent must provide satisfactory evidence of continuous enrollment in other medical coverage from the most recent open enrollment for which enrollment in PEBB was ((~~waived~~)) deferred.

(3) Surviving spouses, Washington state registered domestic partners, or eligible 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 a PEBB health plan 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~~)) Washington state registered domestic partner may continue health plan enrollment until death.

(b) Children may continue health plan enrollment until they lose eligibility under PEBB rules.

(4) Surviving dependents must notify the PEBB ((~~benefits services~~)) program of their decision to enroll or defer enrollment in a PEBB health plan no later than sixty days after the date of death of the employee or retiree. If PEBB health plan enrollment ended due to the death of the employee or retiree, PEBB will reinstate health plan enrollment without a gap subject to payment of premium. In order to avoid duplication of group medical coverage, surviving dependents may defer enrollment in a PEBB health plan under WAC 182-12-200 and 182-12-205. To notify the PEBB ((~~benefits services~~)) program of their intent to enroll or defer enrollment in a PEBB health plan, the surviving dependent must submit the appropriate forms to the PEBB ((~~benefits services~~)) program no later than sixty days after the date of death of the employee or retiree.

AMENDATORY SECTION (Amending Order 08-03, filed 10/1/08, effective 1/1/09)

WAC 182-12-270 What options for continuation coverage are available to dependents who cease to meet the eligibility criteria in WAC 182-12-260? If eligible, dependents may continue health plan enrollment under one of the continuation coverage options in subsection (1) or (2) of this section by self-paying the full premiums set by the HCA, with no contribution from the employer, following their loss of eligibility under the subscriber's health plan coverage. The PEBB ((~~benefits services~~)) program must receive the appropriate forms as outlined in the *PEBB Initial Notice of COBRA and Continuation Coverage Rights*. Options for continuing

health plan enrollment are based on the reason that eligibility was lost.

(1) Spouses, ((~~qualified~~)) Washington state registered domestic partners, or children who lose eligibility due to the death of an employee or retiree may be eligible to continue health plan enrollment under provisions of WAC 182-12-250 or 182-12-265; or

(2) Dependents who lose eligibility because they no longer meet the eligibility criteria in WAC 182-12-260 are eligible to continue health plan enrollment under provisions of the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). See WAC 182-12-146 for more information on COBRA.

Exception: A qualified domestic partner who loses eligibility because he or she no longer meets the eligibility criteria in WAC 182-12-260 may continue health plan enrollment under an extension of PEBB insurance coverage for a maximum of thirty-six months.

No ((~~extension of~~)) PEBB continuation coverage will be offered unless the PEBB ((~~benefits services~~)) program is notified through hand-delivery or United States Postal Service mail of ((~~a completed notice of~~)) the qualifying event as outlined in the *PEBB Initial Notice of COBRA and Continuation Coverage Rights*.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 182-12-112	Insurance eligibility for higher education.
WAC 182-12-115	Eligible employees.
WAC 182-12-121	Does a change in position or job affect eligibility status?

AMENDATORY SECTION (Amending Order 08-03, filed 10/1/08, effective 1/1/09)

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

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

"Agency" means the health care authority;

"Dependent care assistance program" or "DCAP" means a benefit plan whereby state and public employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan authorized in chapter 41.05 RCW.

"Employer group" means those employee organizations representing state civil service employees, counties, municipalities, political subdivisions, tribal governments, school districts, and educational service districts participating in PEBB insurance coverage under contractual agreement as described in WAC 182-08-230.

"Employing agency" means a division, department, or separate agency of state government, including an institution of higher education; a county, municipality, school district, educational service district, or other political subdivision; or a tribal government covered by chapter 41.05 RCW.

"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.

"Health plan" or "plan" means a medical or dental plan developed by the public employees benefits board and provided by a contracted vendor or self-insured plans administered by the HCA.

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

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby state and public employees may reduce their salary before taxes to pay for medical expenses not reimbursed by insurance as provided in the salary reduction plan authorized in chapter 41.05 RCW.

"PEBB" means the public employees benefits board.

"PEBB appeals committee" means the committee that considers appeals relating to the administration of PEBB benefits by the PEBB ((~~benefits services~~)) program. The administrator has delegated the authority to hear appeals at the level below an administrative hearing to the PEBB appeals committee.

"PEBB benefits" means one or more insurance coverage or other employee benefit administered by the PEBB ((~~benefits services~~)) program within the HCA.

"PEBB ((~~benefits services~~)) program" means the program within the ((~~health care authority~~)) HCA which administers insurance and other benefits for eligible employees (as defined in WAC ((~~182-12-115~~)) 182-12-114), eligible retired and disabled employees of the state (as defined in WAC 182-12-171), eligible dependents (as defined in WAC 182-12-250 and 182-12-260), and others as defined in RCW 41.05.011.

"Premium payment plan" means a benefit plan whereby state and public employees may pay their share of group health plan premiums with pretax dollars as provided in the salary reduction plan.

"Salary reduction plan" means a benefit plan whereby state and public employees may agree to a reduction of salary on a pretax basis to participate in the DCAP, medical FSA, or premium payment plan as authorized in chapter 41.05 RCW.

"State agency" means an office, department, board, commission, institution, or other separate unit or division, however designated, of the state government and all personnel thereof. It includes the legislature, executive branch, and agencies or courts within the judicial branch, as well as institutions of higher education and any unit of state government established by law.

AMENDATORY SECTION (Amending Order 08-03, filed 10/1/08, effective 1/1/09)

WAC 182-16-030 How can an employee or an employee's dependent appeal a decision made by ((~~an employing~~)) a state agency about eligibility or enrollment in benefits? Any employee or employee's dependent aggrieved by a decision made by ((~~an employing~~)) a state agency with regard to public employee benefits eligibility or enrollment may appeal that decision to the ((~~employing~~))

state agency. Any dependent aggrieved by a decision made by the PEBB program may appeal the decision by submitting an appeal to the PEBB appeals committee in the same manner as a self-pay enrollee as described in WAC 182-16-032.

Any employer group employee or employee's dependent aggrieved by a decision with regard to PEBB eligibility, enrollment or premium payment may appeal that decision to the employer group. Appeals to employer groups are not subject to this rule.

Note: Eligibility decisions address whether an employee or an employee's dependent is entitled to insurance coverage, as described in PEBB rules and policies. Enrollment decisions address the application for PEBB benefits as described in PEBB rules and policies, including but not limited to the submission of proper documentation and meeting enrollment deadlines.

The ((~~employing~~)) state agency may only reverse eligibility or enrollment decisions based on circumstances that arose due to delays caused by the ((~~employing~~)) state agency or error(s) made by the ((~~employing~~)) state agency.

(1) Any employee or employee's dependent aggrieved by an eligibility or enrollment decision made by ((~~an employing~~)) a state agency may appeal the decision by submitting a written request for review to the ((~~employing~~)) state agency. The ((~~employing~~)) state agency must receive the request for review within thirty days of the date of the initial denial notice. The contents of the request for review are to be provided in accordance with WAC 182-16-040.

(a) Upon receiving the request for review, the ((~~employing~~)) state agency shall make a complete review of the initial denial by one or more staff who did not take part in the initial denial. As part of the review, the ((~~employing~~)) state agency may hold a formal meeting or hearing, but is not required to do so.

(b) The ((~~employing~~)) state agency shall render a written decision within thirty days of receiving the request for review. The written decision shall be sent to the appellant.

(c) A copy of the ((~~employing~~)) state agency's written decision shall be sent to the ((~~employing~~)) state agency's administrator or designee and to the PEBB appeals manager. The ((~~employing~~)) state agency's written decision shall become the ((~~employing~~)) state agency's final decision effective fifteen days after the date it is rendered.

(2) Any employee or employee's dependent who disagrees with the ((~~employing~~)) state agency's decision in response to a request for review, as described in subsection (1) of this section, may appeal that decision by submitting a notice of appeal to the PEBB appeals committee. The PEBB appeals manager must receive the notice of appeal within thirty days of the date of the ((~~employing~~)) state agency's written decision on the request for review.

As well, any employee or employee's dependent may appeal a decision about premium payments by submitting a notice of appeal to the PEBB appeals committee. The PEBB appeals manager must receive the notice of appeal within thirty days of the date of the denial notice. The contents of the notice of appeal are to be provided in accordance with WAC 182-16-040.

(a) The PEBB appeals manager shall notify the appellant in writing when the notice of appeal has been received.

(b) The PEBB appeals committee shall render a written decision within thirty days of receiving the notice of appeal. The written decision shall be sent to the appellant.

(c) Any appellant who disagrees with the decision of the PEBB appeals committee may request an administrative hearing, as described in WAC 182-16-050.

AMENDATORY SECTION (Amending Order 08-03, filed 10/1/08, effective 1/1/09)

WAC 182-16-032 How can a retiree ((~~or~~)), self-pay enrollee, or dependent appeal a decision made by the PEBB ((~~benefits services~~)) program regarding eligibility, enrollment or premium payments? Any retiree ((~~or~~)), self-pay enrollee, or dependent aggrieved by a decision made by the PEBB ((~~benefits services~~)) program with regard to public employee benefit eligibility, enrollment, or premium payments may appeal the decision to the PEBB appeals committee.

Note: Eligibility decisions address whether a retiree, self-pay enrollee or their dependent is entitled to insurance coverage, as described in PEBB rules and policies. Enrollment decisions address the application for PEBB benefits as described in PEBB rules and policies, including, but not limited to the submission of proper documentation, enrollment deadlines, and premium related issues.

The PEBB appeals manager must receive the notice of appeal within sixty days of the date of the denial notice by the PEBB ((~~benefits services~~)) program. The contents of the notice of appeal are to be provided in accordance with WAC 182-16-040.

(1) The PEBB appeals manager shall notify the appellant in writing when the notice of appeal has been received.

(2) The PEBB appeals committee shall render a written decision within thirty days of receiving the notice of appeal. The written decision shall be sent to the appellant.

(3) Any appellant who disagrees with the decisions of the PEBB appeals committee may request an administrative hearing, as described in WAC 182-16-050.

AMENDATORY SECTION (Amending Order 08-03, filed 10/1/08, effective 1/1/09)

WAC 182-16-034 How can a PEBB enrollee appeal a decision regarding the administration of a PEBB medical plan, insured dental plan, life insurance, long-term care insurance, long-term disability insurance, or property or casualty insurance? Any PEBB enrollee aggrieved by a decision regarding the administration of a PEBB medical plan, insured dental plan, life insurance, long-term care insurance, long-term disability insurance, or property and casualty insurance may ((~~do so~~)) appeal that decision by following the appeal provisions of those plans. Those appeals are not subject to this chapter, except for eligibility, enrollment and premium payment determinations. Employees and their dependents should refer to WAC 182-16-030 for eligibility, enrollment and premium payment appeals. Retirees, self-pay enrollees, and their dependents should refer to WAC 182-16-032 for eligibility, enrollment and premium payment appeals.

AMENDATORY SECTION (Amending Order 08-03, filed 10/1/08, effective 1/1/09)

WAC 182-16-036 How can an enrollee appeal a decision regarding the administration of benefits offered under the state's salary reduction plan? (1) Any enrollee aggrieved by a decision regarding the medical FSA and DCAP offered under the state's salary reduction plan may appeal that decision to the third-party administrator contracted to administer the plan.

(2) Any enrollee who disagrees with a decision in response to an appeal filed with the third-party administrator that administers the medical FSA and DCAP under the state's salary reduction plan may appeal to the PEBB appeals committee. The PEBB appeals manager must receive the notice of appeal within thirty days of the date of the appeal decision by the third-party administrator that administers the medical FSA and DCAP offered under the state's salary reduction plan. The contents of the notice of appeal are to be provided in accordance with WAC 182-16-040.

(a) The PEBB appeals manager shall notify the appellant in writing when the notice of appeal has been received.

(b) The PEBB appeals committee shall render a written decision within thirty days of receiving the notice of appeal. The written decision shall be sent to the appellant.

(c) Any appellant who disagrees with the decision of the PEBB appeals committee may request an administrative hearing, as described in WAC 182-16-050.

(3) Any enrollee aggrieved by a decision regarding the administration of the premium payment plan offered under the state's salary reduction plan may appeal that decision to the PEBB appeals committee. The PEBB appeals manager must receive the notice of appeal within thirty days of the date of the denial notice by the PEBB ((~~benefits services~~)) program. The contents of the notice of appeal are to be provided in accordance with WAC 182-16-040.

(a) The PEBB appeals manager shall notify the appellant in writing when the notice of appeal has been received.

(b) The PEBB appeals committee shall render a written decision within thirty days of receiving the notice of appeal. The written decision shall be sent to the appellant.

(c) Any appellant who disagrees with the decision of the PEBB appeals committee may request an administrative hearing, as described in WAC 182-16-050.

AMENDATORY SECTION (Amending Order 08-03, filed 10/1/08, effective 1/1/09)

WAC 182-16-037 How can an enrollee appeal a decision by the agency's self-insured dental plan? Any enrollee aggrieved by a decision by the agency's self-insured dental plan (Uniform Dental Plan) may appeal that decision to the PEBB appeals committee. The PEBB appeals manager must receive the notice of appeal within thirty days of the date of the denial notice by the agency's self-insured dental plan. The contents of the notice of appeal are to be provided in accordance with WAC 182-16-040.

(1) The PEBB appeals manager shall notify the appellant in writing when the notice of appeal has been received.

(2) The PEBB appeals committee shall render a written decision within thirty days of receiving the notice of appeal. The written decision shall be sent to the appellant.

(3) Any appellant who disagrees with the decision of the PEBB appeals committee may request an administrative hearing, as described in WAC 182-16-050.

WSR 09-20-057
PROPOSED RULES
HEALTH CARE AUTHORITY
(Community Health Services)
(Community Collaborative Grant Program)
[Order 09-03—Filed October 2, 2009, 9:54 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 09-16-092.

Title of Rule and Other Identifying Information: WAC 182-20-600 Community health care collaborative program, 182-20-610 Administration, and 182-20-620 Application process, to reflect legislative changes pursuant to SSB 5360, chapter 299, Laws of 2009.

Hearing Location(s): The Washington State Health Care Authority, 676 Woodland Square Loop S.E., The Sue Crystal Center, Lacey, WA 98504, on November 10, 2009, at 9:00 a.m.

Date of Intended Adoption: November 17, 2009.

Submit Written Comments to: Jan Ward Olmstead, 676 Woodland Square Loop S.E., P.O. Box 42721, Lacey, WA 98504, e-mail Jan Ward Olmstead, fax (360) 923-2803, by close of business on November 10, 2009.

Assistance for Persons with Disabilities: Contact Nikki Johnson by November 3, 2009, TTY (888) 923-5622 or (360) 923-2805.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The purpose of the proposed rules is to use a public process, allowing for input to the development and implementation of the community health care collaborative grant program. The rules will allow for community health services, under the direction of the administrator of the authority, to administer the collaborative program, define eligibility requirements, and set parameters for the allocation of grant funding.

Reasons Supporting Proposal: The 2009 Washington state legislature created the community health care collaborative grant program and appropriated funds in the 2009-11 biennium to Washington state health care authority for the implementation of the program. The proposed rules set the parameters to administer the program.

Statutory Authority for Adoption: RCW 41.05.220 and 41.05.230.

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

Name of Proponent: Washington state health care authority, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation and Enforcement: Jan Ward Olmstead, 676 Woodland Square Loop S.E., Lacey, WA, (360) 923-2803.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The joint administrative rules review committee has not requested the filing of a small business economic impact statement, and there will be no costs to small businesses.

A cost-benefit analysis is not required under RCW 34.05.328. RCW 34.05.328 does not apply to the health care authority rules unless requested by the joint administrative rules [review] committee or applied voluntarily.

October 2, 2009
Jason Siems
Rules Coordinator

AMENDATORY SECTION (Amending Order 06-07, filed 12/28/06, effective 1/28/07)

WAC 182-20-600 Community health care collaborative program. ((~~The community health care collaborative grant program was established July 1, 2006, to develop innovative health care delivery models. The funding covers a two-year cycle; half of the award to be distributed throughout the first year and the final half distributed throughout the second year upon evidence of successful program progress and achieving grant objectives, based upon available funding.~~)) The purpose of this chapter is to establish procedures for the community health care collaborative grant program. The authority is responsible for disbursing funds to further the efforts of community-based organizations that address:

(1) Access to medical treatment;

(2) Efficient use of health care resources; or

(3) Improve quality of care.

The program is a two-year grant. The continuation of disbursement of funds for the second year of the grant is determined upon recipients' satisfactory performance measures reported for the first year.

The authority may also subcontract administrative activities with a statewide community health care organization that can facilitate program policy regarding best practices and standardized performance measures among grantees.

AMENDATORY SECTION (Amending Order 06-07, filed 12/28/06, effective 1/28/07)

WAC 182-20-610 Administration. The authority is responsible for:

(1) ((~~Preaward~~)) Grant development((~~:~~)), including:

(a) ((~~Develop~~)) Setting criteria for the selection of community-based organizations to receive grant funding;

(b) ((~~Develop~~)) Determining equitable standards governing the granting of awards;

(c) ((~~Determine~~)) Determining nature and format of the application and process.

(2) Award determinations((~~:~~)), including:

(a) ((~~Consult with representatives, appointed by the secretary of the department of health, the assistant secretary of health and recovery services administration within the department of social and health services, and the office of the insurance commissioner to make recommendations for final applicant selection and grant determination~~)) Accepting grant applications;

(b) Selecting recipients based upon documented health care access and quality improvement goals aligned with state health priorities;

(((~~(b) The administrator will review recommendations~~)) (c) Reviewing and ((~~make~~)) making final determination based upon ((~~recommendations, funds available and utilization of resources to meet the goals of the program;~~

(~~c) Conduct~~)) the applicant's ability to:

(i) Meet the eligibility criteria;

(ii) Meet the program goals; and

(iii) Best utilize funds and resources available to meet the goals of the program;

(d) Conducting on-site visits to ensure applicant's ability to achieve grant objectives and performance measures identified in the application;

(((~~(d) Contract~~)) (e) Contracting with successful applicants; and

(((~~(e) Disburse~~)) (f) Disbursing grant funds according to program policy.

(3) Post-award actions((~~:~~)), including:

(a) ((~~Review~~)) Reviewing periodic progress reports from contractors;

(b) ((~~Conduct~~)) Conducting on-site visits of contractors to provide assistance and ensure compliance of grant objectives as necessary;

(c) ((~~Consult with representatives from department of health, the assistant secretary of health and recovery services administration within the department of social and health services, and office of the insurance commissioner, one year following initial disbursement, to make recommendations to administrator for disbursement of the second half of grant funds, based upon performance measures identified in the application and evidence of successful program progress and achieving grant objectives~~)) Reviewing and approving distribution of the second half of a grant based upon satisfactory performance reports; and

(d) ((~~The administrator will review and make final determination for grant disbursements; and~~

(~~e) Compile a report to the governor and legislature on July 1, 2008, which~~)) Compiling periodic reports as requested by the governor and legislature, which may include:

(i) ((~~Describes~~)) Description of organizations and programs funded;

(ii) ((~~Describes~~)) Description and ((~~analyzes~~)) analysis of results achieved;

(iii) ((~~Makes~~)) Recommendations for improvements to the program; and

(iv) Highlights best practices that can be replicated statewide.

AMENDATORY SECTION (Amending Order 06-07, filed 12/28/06, effective 1/28/07)

WAC 182-20-620 Application process. (1) Eligibility.

(a) Applicants must ((~~provide the following in~~)) meet the application ((~~format~~)) requirements prescribed by the authority.

(b) Applicants must be able to show:

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

(ii) Evidence of the specific geographic region served ((~~and~~));

(iii) Evidence of a formal collaborative ((~~governing~~)) governance structure ((~~by documentation that may include, but is not limited to:~~

~~(A) Bylaws;~~

~~(B) Agreements;~~

~~(C) Contracts;~~

~~(D) Memorandum of understanding;~~

~~(E) Minutes;~~

~~(F) Letters; or~~

~~(G) Other communications~~)) and decision-making process that demonstrates structure, operation, and accountability to the region served;

((~~(iii)~~)) (iv) Evidence of representation from hospitals, public health, behavioral health, community health centers, rural health clinics, and private practitioners that serve low-income persons in the region, unless there are no such providers within the region, or providers decline or refuse to participate or place unreasonable conditions on their participation;

(v) Amount of funds requested and how the dollars will be spent;

((~~(iv)~~)) (vi) Data to evaluate program progress and ability to meet grant objectives.

((~~(b)~~)) (c) Applicants will be evaluated competitively on their ability to:

(i) Address documented health care access and quality improvement goals aligned with state policy priorities and health care needs in the specific region served;

(ii) ((~~Engage~~)) Document engagement of key community members;

(iii) ((~~Show~~)) Document evidence of matching funds of at least two dollars for each grant dollar requested. All matching fund contributions((~~, including cash and in-kind, shall~~)) must meet the criteria determined by the administrator and ((~~included in~~)) the application guidelines;

(iv) ((~~Ability to meet the documented health care needs and~~)) Address how the grant will enhance long-term capacity and sustainability of programs;

(v) Show innovation in program approaches that could be replicated throughout the state;

(vi) Make efficient and cost-effective use of funds by simplifying administration affecting the health care delivery system;

(vii) Clearly describe size of organization, program objectives, and populations served((~~; and~~

~~(viii) Meet the reporting requirements of the authority~~)).

((~~(c)~~)) (d) Application access.

(i) The call for grant applications will be made by posting the announcement to the authority's official web site and by notification sent to interested parties.

(ii) To be placed on the interested parties' distribution list, send contact information, including mailing and e-mail addresses to community health care collaboration at Washington State Health Care Authority, P.O. Box 42721, Olympia, Washington 98504-2721.

(2) The guidelines and application forms will be available on the authority's official web site and included with the published guidelines distributed by e-mail to those who request an application. The application will be available in hard copy and sent by United States mail upon request. Applications must be completed and submitted in the format and filed by the deadlines prescribed by the authority and published in the guidelines.

WSR 09-20-060
PROPOSED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Disability Services Administration)

[Filed October 2, 2009, 1:51 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 09-15-156.

Title of Rule and Other Identifying Information: The department intends to amend chapter 388-76 WAC, Adult family home minimum licensing requirement sections. The department intends to amend WAC 388-76-10000 Definitions, 388-76-10015 License—Adult family home—Compliance required, 388-76-10020 License—Ability to provide care and services, 388-76-10030 License capacity, 388-76-10050 License—Relinquishment, 388-76-10055 Application—Generally, 388-76-10080 Application—Coprovider, 388-76-10115 Granting or denying a license—Generally, 388-76-10120 License—Must be denied, 388-76-10125 License—May be denied, 388-76-10180 Employment—Certain criminal history—Prohibited, 388-76-10195 Adult family home—Staff—Generally, 388-76-10225 Reporting requirement, 388-76-10270 Tuberculosis—Testing method—Required, 388-76-10275 Tuberculosis—No testing, 388-76-10280 Tuberculosis-One step testing, 388-76-10285 Tuberculosis—Two step skin testing, 388-76-10290 Tuberculosis—Positive test results, 388-76-10295 Tuberculosis—Negative skin test results, 388-76-10300 Tuberculosis—Declining a skin test, 388-76-10305 Tuberculosis—Reporting—Required, 388-76-10310 Tuberculosis—Test records, 388-76-10420 Meals and snacks, 388-76-10455 Medication—Administration, 388-76-10490 Medication disposal—Written policy—Required, 388-76-10520 Resident rights—General notice, 388-76-10540 Resident rights—Disclosure of fees and notice requirements—Deposits, 388-76-10673 Abuse and neglect reporting—Mandated reporting to department—Required, 388-76-10685 Bedrooms, 388-76-10750 Safety and maintenance, 388-76-10820 Resident evacuation capabilities and location of resident bedrooms, 388-76-10840 Emergency food supply, 388-76-10845 Emergency drinking water supply, 388-76-10870 Resident evacuation capability levels—Identification required, 388-76-10880 Emergency evacuation adult family home bedrooms, 388-76-10920 Inspection and investigation reports—Provided by department, 388-76-10955 Remedies—Department must impose remedies, 388-76-10960 Remedies—Department may impose remedies, 388-10990 Informal dispute res-

olution (IDR), 388-76-10995 Notice, hearing rights, and effective dates relating to imposition of remedies, 388-76-11005 Resident protection program—Notification of preliminary finding to individual, 388-76-11010 Resident protection program—Notification of preliminary finding to others, 388-76-11015 Resident protection program—Disputing a preliminary finding, 388-76-11025 Resident protection program—Finalizing a preliminary finding, 388-76-11030 Resident protection program—Appeal of administrative law judge's initial order or finding, 388-76-11035 Resident protection program—Reporting final findings, and 388-76-11040 Resident protection program—Disclosure of investigative and finding information.

The department intends to create the following new sections WAC 388-76-10002 Department authority, 388-76-10003 Department access, 388-76-10057 Application—General qualifications, 388-76-10063 Application—General training requirements, 388-76-10064 Application—Forty-eight hour class training requirements, 388-76-10103 Application—Liability insurance required, 388-76-10129 Qualifications—Adult family home personnel, 388-76-10191 Liability insurance required—Ongoing, 388-76-10192 Liability insurance required—Professional liability insurance coverage, 388-76-10193 Liability insurance required—Commercial general liability insurance or business liability insurance coverage, 388-76-10198 Adult family home—Personnel records, 388-76-10522 Resident rights notice—Policy on accepting medicaid as a payment source, 388-76-11004 Resident protection program—Individual defined, 388-76-11050 Management Agreements—General, 388-76-11055 Management Agreements—Adult family home, 388-76-11060 Terms of the management agreement, 388-76-11065 Management agreements—Department review, 388-76-11070 Management agreements—Resident funds, 388-76-11080 Notice—Complete, and 388-76-11085 Notice—Proof.

The department intends to repeal WAC 388-76-10190 Adult family home—Compliance with regulations—Required.

Hearing Location(s): Blake Office Park East, Rose Room, 4500 10th Avenue S.E., Lacey, WA 98503 (one block north of the intersection of Pacific Avenue S.E. and Alhadeff Lane. A map or directions are available at http://www1.dshs.wa.gov/msa/rpau/docket.html or by calling (360) 664-6094), on December 8, 2009, at 10:00 a.m.

Date of Intended Adoption: Not earlier than December 9, 2009.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504-5850, delivery 4500 10th Avenue S.E., Lacey, WA 98503, e-mail DSHSRPAURulesCoordinator@dshs.wa.gov, fax (360) 664-6185, by 5 p.m. on December 8, 2009.

Assistance for Persons with Disabilities: Contact Jennisha Johnson, DSHS rules consultant, by November 24, 2009, TTY (360) 664-6178 or (360) 664-6094 or by e-mail at johnsjl4@dshs.wa.gov.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The purpose of this proposed rule making is to make editorial and clarifying changes and to make them consistent with current laws and standards. The impact of the proposed rule is to make the rule clearer, easier to read, understand, and apply.

Statutory Authority for Adoption: RCW 70.128.040.

Statute Being Implemented: Chapter 70.128 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: Maureen Lally, P.O. Box 45600, Olympia, WA 98504-5600, (360) 725-3204; Implementation and Enforcement: Lori Melchiori, P.O. Box 45600, Olympia, WA 98504-5600, (360) 725-2404.

A small business economic impact statement has been prepared under chapter 19.85 RCW.

Small Business Economic Impact Statement

See Reviser's note below.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Maureen Lally, Program Manager, P.O. Box 45600, Olympia, WA 98504-5600, phone (360) 725-3204, fax (360) 438-7903, e-mail lallyma@dshs.wa.gov.

September 30, 2009
Stephanie E. Vaughn
Rules Coordinator

Reviser's note: The material contained in this filing exceeded the page-count limitations of WAC 1-21-040 for appearance in this issue of the Register. It will appear in the 09-22 issue of the Register.

WSR 09-20-061
PROPOSED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Disability Services Administration)

[Filed October 2, 2009, 2:28 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 09-14-069.

Title of Rule and Other Identifying Information: The department is amending and creating new sections to chapter 388-78A WAC regarding boarding home rules. The department is proposing amendments to WAC 388-78A-2060 Preadmission assessment, 388-78A-2300 Food and nutrition services, 388-78A-2440 Resident register, 388-78A-2470 Criminal history disclosure and background checks, 388-78A-2480 Tuberculosis—Testing—Required, 388-78A-2520 Administrator qualifications—General, 388-78A-2540 Administrator requirements, 388-78A-2590 Management agreements—General, 388-78A-2910 Applicable building codes, 388-78A-3030 Toilet rooms and bathrooms, 388-78A-3190 Denial, suspension, revocation, or nonrenewal of license statutorily required, 388-78A-3410 Resident protection program—Notice to the individual of preliminary finding, 388-78A-3420 Resident protection program—Notice to others of preliminary findings, 388-78A-3430 Resident pro-

tection program—Disputing a preliminary finding, 388-78A-3450 Resident protection program—Finalizing a preliminary finding, 388-78A-3460 Resident protection program—Appeal of initial order, 388-78A-3470 Resident protection program—Reporting final findings, and 388-78A-3480 Resident protection program—Disclosure of investigative and finding information.

The department is proposing new sections WAC 388-78A-2481 Tuberculosis—Testing method—Required, 388-78A-2482 Tuberculosis—No testing, 388-78A-2483 Tuberculosis—One step testing, 388-78A-2484 Tuberculosis—Two step skin testing, 388-78A-2485 Tuberculosis—Positive test result, 388-78A-2486 Tuberculosis—Negative test result, 388-78A-2487 Tuberculosis—Declining a skin test, 388-78A-2488 Tuberculosis—Reporting—Required, 388-78A-2489 Tuberculosis—Test records, 388-78A-2521 Certification of training, 388-78A-2522 Administrator qualifications—Prior to 2004, 388-78A-2523 Administrator qualification—NH administrator license, 388-78A-2524 Administrator qualifications—Certification of training and three years experience, 388-78A-2525 Administrator qualifications—Associate degree, certification of training, and two years experience, 388-78A-2526 Administrator qualifications—Bachelor's degree, certification of training and one year experience, 388-78A-2527 Administrator qualifications—Five years experience, 388-78A-2592 Management agreements—Licensee, 388-78A-2593 Management agreements—Terms of agreement, 388-78A-2594 Management agreements—Department review, 388-78A-2595 Management agreements—Resident funds, 388-78A-2665 Resident rights—Notice—Policy on accepting medicaid as a payment source, 388-78A-2731 Application—Liability insurance required, 388-78A-2732 Liability insurance required—Ongoing, 388-78A-2733 Liability insurance required—Commercial general liability insurance or business liability insurance coverage, 388-78A-2734 Liability insurance required—Professional liability insurance coverage, 388-78A-3390 Resident protection program—Individual defined, 388-78A-4000 Notice—Service complete, and 388-78A-4010 Notice—Proof of service.

Hearing Location(s): Blake Office Park East, Rose Room, 4500 10th Avenue S.E., Lacey, WA 98503 (one block north of the intersection of Pacific Avenue S.E. and Alhadeff Lane. A map or directions are available at http://www.dshs.wa.gov/msa/rpau/docket.html or by calling (360) 664-6094), on December 8, 2009, at 10:00 a.m.

Date of Intended Adoption: Not earlier than December 9, 2009.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504-5850, delivery 4500 10th Avenue S.E., Lacey, WA 98503, e-mail DSHSRPAURulesCoordinator@dshs.wa.gov, fax (360) 664-6185, by 5 p.m. on December 8, 2009.

Assistance for Persons with Disabilities: Contact Jennisha Johnson, DSHS rules consultant, by November 24, 2009, TTY (360) 664-6178 or (360) 664-6094 or by e-mail at johnsjl4@dshs.wa.gov.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The purpose of amending these rules is to consider making editorial and clarifying changes and to make these rules consistent with current law and standards. The anticipated effects are to make the rule clearer, easier to read, understand and apply.

- Editorial and housekeeping changes in the following sections: Preadmission assessment, food and nutrition services, resident register, toilet rooms and bathrooms.
- Added disclosure requirement regarding the facility's policy on accepting medicaid payments to be consistent with RCW 18.20.440 and SSB 6009.
- Clarified tuberculosis requirements to be consistent with current standards.
- Clarified when notice is considered complete and proof of notice.
- Consolidated disqualifying crime lists.
- Added liability insurance requirement to rule.
- Clarified management agreement requirements.
- Clarified resident protection program requirements.
- Clarified that new construction must comply with rules in effect at the time of plan approval except in cases where resident health and safety may be jeopardized.
- Chunked large administrator qualifications section into smaller sections.

Reasons Supporting Proposal: See above.

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: Judy Johnson, P.O. Box 45600, Olympia, WA 98513, (360) 725-2591; Implementation and Enforcement: Lori Melchiori, P.O. Box 45600, Olympia, WA 98513, (360) 725-2404.

A small business economic impact statement has been prepared under chapter 19.85 RCW.

Small Business Economic Impact Statement

See Reviser's note below.

A copy of the statement may be obtained by contacting Judy Johnson, Boarding Home Program Manager, P.O. Box 45600, Olympia, WA 98504-5600, phone (360) 725-2591, fax (360) 438-7903, e-mail johnsjm1@dshs.wa.gov.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Judy Johnson, Boarding Home Program Manager, P.O. Box 45600, Olympia, WA 98504-5600, phone (360) 725-2591, fax (360) 438-7903, e-mail johnsjm1@dshs.wa.gov.

October 1, 2009

Stephanie E. Vaughn

Rules Coordinator

Reviser's note: The material contained in this filing exceeded the page-count limitations of WAC 1-21-040 for appearance in this issue of the Register. It will appear in the 09-22 issue of the Register.

WSR 09-20-062
PROPOSED RULES
DEPARTMENT OF
SOCIAL AND HEALTH SERVICES
(Aging and Disability Services Administration)
[Filed October 2, 2009, 2:33 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 09-14-070.

Title of Rule and Other Identifying Information: The department is amending WAC 388-97-0001 Definitions, 388-97-0100 Utilization review, 388-97-0280 Advance directives, 388-97-0580 Roommates/room, 388-97-0720 Notification of preliminary finding, 388-97-1400 Tuberculosis-testing method—Required, 388-97-1440 Tuberculosis—No skin testing, 388-97-1460 Tuberculosis—One step testing, 388-97-1480 Tuberculosis—Two step skin testing, 388-97-1500 Tuberculosis—Positive test result, 388-97-1520 Tuberculosis—Negative test result, 388-97-1540 Tuberculosis—Declining a skin test, 388-97-1560 Tuberculosis—Reporting required, 388-97-1580 Tuberculosis—Test records, 388-97-1600 Care of residents with active tuberculosis, 388-97-1800 Criminal history disclosure and background inquiries, 388-97-1820 Disqualification from nursing home employment, 388-97-1900 Dialysis services provided in nursing home, 388-97-2060 New construction compliance, 388-97-2280 Call systems on resident care units, 388-97-4200 Department review of initial nursing home license applications, 388-97-4220 Reasons for denial, suspension, modification, revocation of, or refusal to renew a nursing home license, 388-97-4320 Relocation of residents, 388-97-4340 License relinquishment, 388-97-4440 Notice and appeal rights, and other related rules as appropriate.

The department is proposing new sections WAC 388-97-0725 Notice to others of preliminary findings, 388-97-1910 Dialysis services provided outside of nursing home, 388-97-4165 Application—Liability insurance required, 388-97-4166 Liability insurance required—Ongoing, 388-97-4167 Liability insurance required—Commercial general liability insurance or businesses liability insurance coverage, 388-97-4168 Liability insurance required—Professional liability insurance coverage, 388-97-4425 Notice—Service complete, and 388-97-4430 Notice—Proof of service.

The department is proposing to repeal sections WAC 388-97-1420 Tuberculosis—Mantoux skin testing, 388-97-3820 Stairways, ramps, and corridors in new construction, and removing incorrect statutory authority reference 42 C.F.R. 489.52. in the footnote in all sections of chapter 388-97 WAC.

Hearing Location(s): Blake Office Park East, Rose Room, 4500 10th Avenue S.E., Lacey, WA 98503 (one block north of the intersection of Pacific Avenue S.E. and Alhadeff Lane. A map or directions are available at http://www.dshs.wa.gov/msa/rpau/docket.html or by calling (360) 664-6094), on December 8, 2009, at 10:00 a.m.

Date of Intended Adoption: Not earlier than December 9, 2009.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504-5850, delivery 4500 10th Avenue S.E., Lacey, WA 98503, e-mail DSHSRPAURulesCoordinator@dshs.wa.gov, fax (360) 664-6185, by 5 p.m. on December 8, 2009.

Assistance for Persons with Disabilities: Contact Jennisha Johnson, DSHS rules consultant, by November 24, 2009, TTY (360) 664-6178 or (360) 664-6094 or by e-mail at johnsjl4@dshs.wa.gov.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The purpose of amending these rules is to consider making editorial and clarifying changes, and to make it consistent with current laws and standards. Also to remove an incorrect statutory authority reference in the footnote. The anticipated effects are to make the rule clearer, easier to read, understand and apply.

Highlights of proposed changes:

- Editorial and housekeeping changes in the following sections: Definitions, utilization, call systems, new construction, notice and appeal rights, advance directives.
- To be consistent with chapter 521, Laws of 2009, E2SSB 5688 clarified that domestic partners could share a room.
- Clarified tuberculosis requirements to be consistent with current standards.
- Clarified when notice is considered complete and proof of notice.
- Consolidated disqualifying crime lists to make home and community services and RCS lists consistent.
- Clarified dialysis services provided in the nursing home and those provided outside the home.
- Added liability insurance requirement to rule.
- Clarified that nursing home may not need to relinquish license and cease operations if residents are relocated due to natural disasters.
- Clarified that new construction must comply with rules in effect at the time of plan approval except in cases where resident health and safety may be jeopardized.

Reasons Supporting Proposal: See above.

Statutory Authority for Adoption: Chapters 18.51 and 74.42 RCW.

Statute Being Implemented: Chapters 18.51 and 74.42 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: Lisa N.H. Yanagida, P.O. Box 45600, Olympia, WA 98513, (360) 725-2589; Implementation and Enforcement: Lori Melchiori, P.O. Box 45600, Olympia, WA 98513, (360) 725-2404.

A small business economic impact statement has been prepared under chapter 19.85 RCW.

Small Business Economic Impact Statement

See Reviser's note below.

A copy of the statement may be obtained by contacting Lisa N.H. Yanagida, Program Manager, P.O. Box 45600,

Olympia, WA 98504-5600, phone (360) 725-2589, fax (360) 438-7903, e-mail yanagln2@dshs.wa.gov.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Lisa N.H. Yanagida, Program Manager, P.O. Box 45600, Olympia, WA 98504-5600, phone (360) 725-2589, fax (360) 438-7903, e-mail yanagln2@dshs.wa.gov.

September 30, 2009
Stephanie E. Vaughn
Rules Coordinator

Reviser's note: The material contained in this filing exceeded the page-count limitations of WAC 1-21-040 for appearance in this issue of the Register. It will appear in the 09-22 issue of the Register.

WSR 09-20-063
PROPOSED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)
[Filed October 2, 2009, 2:36 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 09-14-041.

Title of Rule and Other Identifying Information: The department is amending WAC 388-543-2900 Medical supplies and nondurable medical equipment (MSE)—Reimbursement methodology.

Hearing Location(s): Blake Office Park East, Rose Room, 4500 10th Avenue S.E., Lacey, WA 98503 (one block north of the intersection of Pacific Avenue S.E. and Alhadeff Lane. A map or directions are available at http://www.dshs.wa.gov/msa/rpau/docket.html or by calling (360) 664-6094), on November 10, 2009, at 10:00 a.m.

Date of Intended Adoption: Not earlier than November 11, 2009.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504-5850, delivery 4500 10th Avenue S.E., Lacey, WA 98503, e-mail DSHSRPAURulesCoordinator@dshs.wa.gov, fax (360) 664-6185, by 5 p.m. on November 10, 2009.

Assistance for Persons with Disabilities: Contact Jennisha Johnson, DSHS rules consultant, by October 27, 2009, TTY (360) 664-6178 or (360) 664-6094 or by e-mail at johnsjl4@dshs.wa.gov.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: This amendment is necessary to describe the payment methodology the department will use to meet the legislature's intent that the department continue to meet federal payment standards for durable medical equipment (DME) with a lower overall level of appropriation.

Reasons Supporting Proposal: These amendments are necessary for the department to fully meet the legislative mandate as required under sections 201 and 209 of the state operating budget for the 2009-2011 fiscal years. This will replace the emergency rule which was filed effective August 1, 2009.

Statutory Authority for Adoption: Section 1109, chapter 564, Laws of 2009 (ESHB 1244); RCW 74.04.050, 74.04.057, 74.08.090.

Statute Being Implemented: Section 1109, chapter 564, Laws of 2009 (ESHB 1244).

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: Wendy Boedigheimer, P.O. Box 45504, Olympia, WA 98504-5504, (360) 725-1306; Implementation and Enforcement: Melissa Usitallo [Usitalo], P.O. Box 45564, Olympia, WA 98504-5564, (360) 725-1853.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The department analyzed the proposed rule amendments and concludes that they will impose no new costs on small businesses. The preparation of a comprehensive small business economic impact statement is not required.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Melissa Usitalo, DME Rates Program Manager, P.O. Box 45500, Olympia, WA 98504-5500, phone (360) 725-1853, fax (360) 586-9727, e-mail Melissa.Usitalo@dshs.wa.gov.

September 30, 2009
Stephanie E. Vaughn
Rules Coordinator

AMENDATORY SECTION (Amending WSR 03-19-083, filed 9/12/03, effective 10/13/03)

WAC 388-543-2900 Medical supplies and nondurable medical equipment (MSE)—Reimbursement methodology. (1) ((~~MAA determines rates for each category of medical supplies and non-DME (MSE) using either the~~)) The department sets, evaluates and annually updates rates for each category of medical supplies and nonDME (MSE) in the medical assistance fee schedule using one or more of the following:

(a) ((~~Medicare fee schedule; or~~

~~(b) Manufacturers' catalogs and commercial data bases for price comparisons~~)) The medicare fee schedule, for those items that are included in the fee schedule for the medicare program, as established by the federal centers for medicare and medicaid services (CMS).

(b) For those items not included in the medicare fee schedule, the department uses manufacturers' catalogs and commercial data bases to identify brands to comprise the department's pricing cluster. When establishing the fee for products in a pricing cluster, the maximum allowable fee is the lesser of either:

(i) Eighty-five percent of the average manufacturer's list price; or

(ii) One hundred twenty-five percent of the average dealer cost.

(c) Input from stakeholders or other relevant sources that the department determines to be reliable and appropriate.

(2) ((~~MAA evaluates and updates the maximum allowable fees for MSE as follows~~)) The department's pricing cluster is made up of all the brands for which the department obtains pricing information. However, the department may limit the number of brands included in the pricing cluster if doing so is in the best interests of its clients as determined by the department. The department considers all of the following when establishing the pricing cluster:

(a) ((~~MAA sets the maximum allowable fees for new MSE using one of the following:~~

~~(i) Medicare's fee schedule; or~~

~~(ii) For those items without a medicare fee, commercial data bases to identify brands to make up MAA's pricing cluster. MAA establishes the fee for products in the pricing cluster by using the lesser of either:~~

~~(A) Eighty-five percent of the average manufacturer's list price; or~~

~~(B) One hundred twenty-five percent of the average dealer cost.~~

~~(b) All the brands for which MAA obtains pricing information make up MAA's pricing cluster. However, MAA may limit the number of brands included in the pricing cluster if doing so is in the best interests of its clients. MAA considers all of the following:~~

~~(i) A client's medical needs;~~

~~(ii) Product quality;~~

~~(iii) Cost; and~~

~~(iv) Available alternatives~~)) A client's medical needs;

(b) Product quality;

(c) Cost; and

(d) Available alternatives.

(3) ((~~MAA's~~)) The department's nursing facility per diem rate, established per chapter 74.46 RCW and chapter 388-96 WAC, includes any reusable and disposable medical supplies that may be required for a nursing facility client. ((~~MAA~~)) The department may reimburse the following medical supplies separately for a client in a nursing facility:

(a) Medical supplies or services that replace all or parts of the function of a permanently impaired or malfunctioning internal body organ. This includes, but is not limited to the following:

(i) Colostomy and other ostomy bags and necessary supplies; and

(ii) Urinary retention catheters, tubes, and bags, excluding irrigation supplies;

(b) Supplies for intermittent catheterization programs, for the following purposes:

(i) Long term treatment of atonic bladder with a large capacity; and

(ii) Short term management for temporary bladder atony; and

(c) Surgical dressings required as a result of a surgical procedure, for up to six weeks after surgery.

(4) ((~~MAA~~)) The department considers decubitus care products to be included in the nursing facility per diem rate and does not reimburse for these separately.

WSR 09-20-064
PROPOSED RULES
SUPERINTENDENT OF PUBLIC INSTRUCTION

[Filed October 2, 2009, 3:16 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 09-15-111.

Title of Rule and Other Identifying Information: Chapter 392-142 WAC, Transportation—Replacement and depreciation allocation.

Hearing Location(s): Office of Superintendent of Public Instruction, Wanamaker Room, 600 South Washington Street, Olympia, WA 98504, on December 10, 2009, at 10:00 a.m.

Date of Intended Adoption: December 11, 2009.

Submit Written Comments to: Allan J. Jones, Director, P.O. Box 47200, Olympia, WA 98504-7200, e-mail allan.jones@k12.wa.us, fax (360) 586-6124, by December 1, 2009.

Assistance for Persons with Disabilities: Contact Wanda Griffin by December 1, 2009, TTY (360) 664-3631 or (360) 725-6132.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: To complete the revision process required after the emergency rule change in June 2009 and to make technical clarifications to the school bus reimbursement system.

Statutory Authority for Adoption: RCW 28A.150.290.

Statute Being Implemented: RCW 28A.160.195.

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

Name of Proponent: [Superintendent of public instruction], governmental.

Name of Agency Personnel Responsible for Drafting: Charlie Schreck, Office of Superintendent of Public Instruction, (360) 725-6136; Implementation: Martin Mueller, Office of Superintendent of Public Instruction, (360) 725-5175; and Enforcement: Allan J. Jones, Office of Superintendent of Public Instruction, (360) 725-6120.

No small business economic impact statement has been prepared under chapter 19.85 RCW. These revisions only apply to public school districts.

A cost-benefit analysis is not required under RCW 34.05.328. These revisions only apply to public school districts.

October 2, 2009
Randy I. Dorn
State Superintendent

AMENDATORY SECTION (Amending WSR 05-19-072, filed 9/16/05, effective 10/17/05)

WAC 392-142-255 Deposit of payments in transportation vehicle fund. School districts shall deposit proceeds for the rent, sale, or lease of school buses and replacement payments for school district-owned vehicles in the transportation vehicle fund. School districts shall not deposit school bus depreciation payments for contractor-owned vehicles in the transportation vehicle fund. ((~~For school buses placed on~~

~~the reimbursement system between September 1, 1975, and August 31, 1980, the superintendent of public instruction shall recover ninety percent of the net proceeds of the sale of such vehicles by deduction from the next annual reimbursement allocation. For school buses placed on the reimbursement system between September 1, 1980, and August 31, 1982, the superintendent of public instruction shall recover one hundred percent of the net proceeds of the sale of such vehicles by deduction from the next annual reimbursement allocation.~~))

AMENDATORY SECTION (Amending WSR 03-13-049, filed 6/12/03, effective 7/13/03)

WAC 392-142-260 Allowable uses of transportation vehicle fund. School districts shall use moneys in the transportation vehicle fund for the following purposes:

(1) The purchase of school buses;

(2) Performing major repairs of a school bus receiving prior approval by the superintendent of public instruction. ((~~Repairs costing less than twenty-five percent of the current state determined purchase price for that type and category of vehicle shall not be considered a major repair.~~))

(3) The transfer of moneys from the transportation vehicle fund to the debt service fund exclusively for the payment of debt and interest incurred by the transportation vehicle fund shall not be considered to be a transfer of moneys from the transportation vehicle fund to any other fund within the meaning of RCW 28A.160.130.

WSR 09-20-066
PROPOSED RULES
OFFICE OF INSURANCE COMMISSIONER

[Insurance Commissioner Matter No. R 2009-06—Filed October 5, 2009, 7:47 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 09-14-082.

Title of Rule and Other Identifying Information: Standards for determining insurer's financial condition.

Hearing Location(s): OIC Tumwater Office, Training Room 120, 5000 Capitol Boulevard, Tumwater, WA, http://www.insurance.wa.gov/about/directions.shtml, on November 12, 2009, at 10:00 a.m.

Date of Intended Adoption: November 23, 2009.

Submit Written Comments to: Kacy Scott, P.O. Box 40258, Olympia, WA 98504-0258, e-mail kacys@oic.wa.gov, fax (360) 586-3109, by November 10, 2009.

Assistance for Persons with Disabilities: Contact Lorie Villaflores by November 10, 2009, TTY (360) 586-0241 or (360) 725-7087.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Accreditation standards require that a state's laws contain the National Association of Insurance Commissioner's (NAIC) "Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition" or a substantially similar provision. This provision authorizes the commissioner to order a company that may be in hazardous condition to take necessary corrective action, provide additional reporting, or cease certain practices. The NAIC has recently amended the model. These proposed rules are to amend the existing regulatory standards to bring them in line with the NAIC model.

Reasons Supporting Proposal: These proposed rules will ensure that the insurance commissioner continues to meet accreditation standards.

Statutory Authority for Adoption: RCW 48.02.060, 48.31.435, 48.44.050, and 48.46.200.

Statute Being Implemented: RCW 48.31.030, 48.31.050, 48.31.400, 48.44.160.

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 and Implementation: Dennis Julnes, 5000 Capitol Boulevard, Tumwater, WA 98501, (360) 725-7109; and Enforcement: Jim Odiorne, 5000 Capitol Boulevard, Tumwater, WA 98501, (370) [(360)] 725-7214.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The only domestic small businesses affected by this proposed rule are multiple employer welfare associations (MEWAs). In accordance with Washington law, MEWAs must be subject to the same examination standards and consequences as health care service contractors. Therefore, no small business economic impact statement is necessary because MEWAs must comply as a matter of law, regardless of their business size.

A cost-benefit analysis is not required under RCW 34.05.328. This proposed rule adopts, without any substantive deviation, model rules proposed by the NAIC. Therefore, in accordance with RCW 34.05.328 (5)(b)(iii), no cost-benefit analysis is required.

October 5, 2009
Mike Kreidler
Insurance Commissioner

AMENDATORY SECTION (Amending Order R 92-9, filed 9/9/92, effective 10/10/92)

WAC 284-16-300 Purpose. (1) The purpose of this regulation, WAC 284-16-300 through 284-16-320 is to set forth the standards which the commissioner will use to identify insurers in such condition as to render the continuance of their business hazardous to ((~~the~~)) their policyholders, creditors or to the general public ((~~or to holders of their policies or certificates of insurance~~)).

(2) This regulation shall not be interpreted to limit the powers granted the commissioner by any laws or parts of laws of this state, nor shall this regulation be interpreted to supersede any laws or parts of laws of this state.

AMENDATORY SECTION (Amending Order R 92-9, filed 9/9/92, effective 10/10/92)

WAC 284-16-310 Standards. The following standards, either singly or a combination of two or more, may be considered by the commissioner to determine whether the continued operation of any insurer transacting an insurance business in this state might be deemed to be hazardous to ((~~the~~)) its policyholders, creditors, or the general public. The commissioner may consider:

(1) Adverse findings reported in financial condition ((~~and~~)) reports, market conduct examination reports, audit reports, or actuarial opinions, reports or summaries.

(2) The National Association of Insurance Commissioners Insurance Regulatory Information System and its ((~~related~~)) other financial analysis solvency tools and reports.

(3) ((~~The ratios of commission expense, general insurance expense, policy benefits and reserve increases as to annual premium and net investment income which could lead to an impairment of capital and surplus.~~

~~(4) The insurer's asset portfolio when viewed in light of current economic conditions is not of sufficient value, liquidity, or diversity to assure the company's ability to meet its outstanding obligations as they mature.~~

~~(5)~~)) Whether the insurer has made adequate provision, according to presently accepted actuarial standards of practice, for the anticipated cash flows required by the contractual obligations and related expenses of the insurer, when considered in light of the assets held by the insurer with respect to such reserves and related actuarial items including, but not limited to, the investment earnings on such assets, and the considerations anticipated to be received and retained under such policies and contracts.

(4) The ability of an assuming reinsurer to perform and whether the insurer's reinsurance program provides sufficient protection for the ((~~company's~~)) insurer's remaining surplus after taking into account the insurer's cash flow and the classes of business written as well as the financial condition of the assuming reinsurer.

(((~~6~~))) (5) Whether the insurer's operating loss in the last twelve month period or any shorter period of time, including but not limited to net capital gain or loss, change in nonadmitted assets, and cash dividends paid to shareholders, is greater than fifty percent of such insurer's remaining surplus as regards policyholders in excess of the minimum required.

(6) Whether the insurer's operating loss in the last twelve-month period or any shorter period of time, excluding net capital gains, is greater than twenty percent of the insurer's remaining surplus as regards policyholders in excess of the minimum required.

(7) Whether ((~~any affiliate~~)) a reinsurer, ((~~subsidiary, or reinsurer~~)) obligor or any entity within the insurer's insurance holding company system is insolvent, threatened with insolvency, or delinquent in payment of its monetary or other obligation, and which in the opinion of the commissioner may affect the solvency of the insurer.

(8) ((~~Contingent liabilities~~)) Contingencies, pledges, or guaranties which either individually or collectively involve a total amount which in the opinion of the commissioner may affect the solvency of the insurer.

(9) Whether any "controlling person" of an insurer is delinquent in the transmitting to, or payment of, net premiums to such insurer.

(10) The age and collectibility of receivables.

(11) Whether the management of an insurer, including officers, directors, or any other person who directly or indirectly controls the operation of such insurer, fails to possess and demonstrate the competence, fitness, and reputation deemed necessary to serve the insurer in such position.

(12) Whether management of an insurer has failed to respond to inquiries relative to the condition of the insurer or has furnished false or misleading information concerning an inquiry.

(13) Whether the insurer has failed to meet financial and holding company filing requirements in the absence of a reason satisfactory to the commissioner.

(14) Whether management of an insurer either has filed any false or misleading sworn financial statement, or has released false or misleading financial statement to lending institutions or to the general public, or has made a false or misleading entry, or has omitted an entry of material amount in the books of the insurer.

(((~~14~~))) (15) Whether the insurer has grown so rapidly and to such an extent that it lacks adequate financial ((~~and~~)) or administrative capacity to meet its obligations in a timely manner.

(((~~15~~))) (16) Whether the ((~~company~~)) insurer has experienced or will experience in the foreseeable future, cash flow ((~~and/~~))or liquidity problems.

(17) Whether management has established reserves that do not comply with minimum standards established by state insurance laws, regulations, statutory accounting standards, or sound actuarial principles and standards of practice.

(18) Whether management persistently engages in material under reserving that results in adverse development.

(19) Whether transactions among affiliates, subsidiaries or controlling persons for which the insurer receives assets or capital gains, or both, do not provide sufficient value, liquidity or diversity to assure the insurer's ability to meet its outstanding obligations as they mature.

(20) Any other factor determined by the commissioner to be hazardous to the insurer's policyholders, creditors or general public.

AMENDATORY SECTION (Amending Order R 92-9, filed 9/9/92, effective 10/10/92)

WAC 284-16-320 Manner in which commissioner will exercise authority. (1) For the purpose of making a determination of an insurer's financial condition under this regulation, the commissioner may:

(a) Disregard any credit or amount receivable resulting from transactions with a reinsurer which is insolvent, impaired, or otherwise subject to a delinquency proceeding;

(b) Make appropriate adjustments including disallowance to asset values attributable to investments in or transactions with parents, subsidiaries, or affiliates consistent with the *NAIC Accounting Policies and Procedures Manual*, state laws or regulations;

(c) Refuse to recognize the stated value of accounts receivable if the ability to collect receivables is highly speculative in view of the age of the account or the financial condition of the debtor; or

(d) Increase the insurer's liability in an amount equal to any contingent liability, pledge, or guarantee not otherwise included if there is a substantial risk that the insurer will be called upon to meet the obligation undertaken within the next twelve-month period.

(2) If the commissioner determines that the continued operation of the insurer authorized to transact business in this state may be hazardous to ((~~the~~)) its policyholders, creditors or the general public, then the commissioner may, in conjunction with or in lieu of a notice required or permitted by RCW 48.05.150, issue an order requiring the insurer to:

(a) Reduce the total amount of present and potential liability for policy benefits by reinsurance;

(b) Reduce, suspend, or limit the volume of business being accepted or renewed;

(c) Reduce general insurance and commission expenses by specified methods;

(d) Increase the insurer's capital and surplus;

(e) Suspend or limit the declaration and payment of dividend by an insurer to its stockholders or to its policyholders;

(f) File reports in a form acceptable to the commissioner concerning the market value of an insurer's assets;

(g) Limit or withdraw from certain investments or discontinue certain investment practices to the extent the commissioner deems necessary;

(h) Document the adequacy of premium rates in relation to the risks insured; ((~~or~~))

(i) File, in addition to regular annual statements, interim financial reports on the form adopted by the National Association of Insurance Commissioners or ((~~on~~)) in such format as promulgated by the commissioner;

(j) Correct corporate governance practice deficiencies, and adopt and utilize governance practices acceptable to the commissioner;

(k) Provide a business plan to the commissioner in order to continue to transact business in the state; or

(l) Notwithstanding any other provision of law limiting the frequency or amount of premium rate adjustments, adjust rates for any nonlife insurance product written by the insurer that the commissioner considers necessary to improve the financial condition of the insurer.

If the insurer is a foreign insurer, the commissioner's order may be limited to the extent provided by statute.

(3) Any insurer subject to an order under subsection (2) of this section may make a written demand for a hearing, subject to the requirements of RCW 48.04.010, by specifying in what respects it is aggrieved and the grounds to be relied upon as basis for the relief to be demanded at the hearing.

WSR 09-20-067
PROPOSED RULES
OFFICE OF INSURANCE COMMISSIONER

[Insurance Commissioner Matter No. R 2009-11—Filed October 5, 2009, 8:35 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 09-16-130.

Title of Rule and Other Identifying Information: Reinsurance-intermediary broker and manager licensing and reporting.

Hearing Location(s): Insurance Commissioner's Office, TR 120, 5000 Capitol Boulevard, Tumwater, WA 98504-0255, on November 10, 2009, at 10:00 a.m.

Date of Intended Adoption: November 18, 2009.

Submit Written Comments to: Jim Tompkins, P.O. Box 40258, Olympia, WA 98504-0258, e-mail Jimt@oic.wa.gov, fax (360) 586-3109, by November 9, 2009.

Assistance for Persons with Disabilities: Contact Lorie Villaflores by November 9, 2009, TTY (360) 586-0241 or (360) 725-7087.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Licensed reinsurance intermediary brokers and managers do not always promptly inform the commissioner of changes in the information that was contained in their original application for licensing and are unclear on what changes must be reported. Under this rule making, the commissioner will consider options that will provide clarity as to the information that must be submitted and when it must be submitted. Additionally, the original rule used the session law citations and the proposed rule will amend these citations to the current RCW citations.

Reasons Supporting Proposal: Will consider options that will provide clarity as to when licensed reinsurance intermediaries must report changes to the information that is contained in their original application for licensing and when the information must be submitted.

Statutory Authority for Adoption: RCW 48.02.060 and 48.94.055.

Statute Being Implemented: RCW 48.94.010.

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: Jim Tompkins, P.O. Box 40258, Olympia, WA 98504-0258, (360) 725-7036; Implementation and Enforcement: Jim Odiorne, P.O. Box 40259, Olympia, WA 98504-0259, (360) 725-7214.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The only substantive rule change proposed is the requirement to notify the commissioner within fifteen business days of material changes in the application information, disciplinary action taken by another governmental jurisdiction and conviction of certain felonies. It seems clear that this would not impose more than a minor cost on any business. Therefore, no small business economic impact statement is required.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Jim Tompkins, P.O. Box 40258, Olympia, WA 98504-0258, phone (360) 725-7036, fax (360) 586-3109, e-mail jimt@oic.wa.gov.

October 5, 2009
Mike Kreidler
Insurance Commissioner

AMENDATORY SECTION (Amending Order R 93-15, filed 9/1/93, effective 10/2/93)

WAC 284-13-700 Definitions. (1) Terms used in this regulation (WAC 284-13-700 through ((~~284-13-740~~)) 284-13-760) that are defined in the Reinsurance Intermediary Act (((~~(~~))chapter ((~~48.~~—)) 48.94 RCW((~~, sections 22 through 33, chapter 462, Laws of 1993~~))) ("the act") have the meaning stated there.

(2) Whether a person is an "employee" of the reinsurer for purposes of ((~~section 23 (7)(a), chapter 462, Laws of 1993,~~)) RCW 48.94.005 (7)(a) depends on the facts and is not controlled by a mere ((~~labelling~~)) labeling of the person as an employee in an agreement.

(3) A reinsurer is "licensed in this state" for purposes of ((~~section 23(8), chapter 462, Laws of 1993,~~)) RCW 48.94.005(8) when it holds a certificate of authority to transact the relevant line of insurance.

NEW SECTION

WAC 284-13-715 Changes to information contained in an application for license. A licensed reinsurance intermediary must notify the commissioner within fifteen business days after occurrence of material changes to the information that was included in the application. For example this includes, but is not limited to, a change to:

(1) The reinsurance intermediary's legal name;

(2) The reinsurance intermediary's formation documents if it is a business entity;

(3) The reinsurance intermediary's registered address;

(4) Individuals authorized to act under the license; and

(5) The reinsurance intermediary's designation to receive service of process.

AMENDATORY SECTION (Amending Order R 93-15, filed 9/1/93, effective 10/2/93)

WAC 284-13-720 Financial statement of reinsurance intermediary-manager. A reinsurer shall obtain from each reinsurance intermediary-manager, and a reinsurance intermediary-manager shall give to the reinsurer, annual statements of financial condition prepared by an independent certified public accountant. The form of the statements shall be such that the statements clearly show the results of operations, and the assets, liabilities, and equity of the reinsurance intermediary-manager. Nothing in the act or this regulation (WAC 284-13-700 through ((~~284-13-740~~)) 284-13-760) prevents a reinsurer from requiring additional information, more detail, or a specified format so long as that specified format at least meets the requirements of this section.

AMENDATORY SECTION (Amending Order R 93-15, filed 9/1/93, effective 10/2/93)

WAC 284-13-730 Submission and approval of contracts between reinsurers and reinsurance intermediary—Managers. Contracts filed for approval under ((~~section 28, chapter 462, Laws of 1993,~~)) RCW 48.94.030 must include the provisions required by that section. If those provisions are not in the order given in that section, or if any other provisions precede or separate any of those required provisions, then the submitted contract shall be accompanied by a statement showing where in the contract each required provision is.

AMENDATORY SECTION (Amending Order R 93-15, filed 9/1/93, effective 10/2/93)

WAC 284-13-740 Reporting of claims. The reporting threshold under ((~~section 28 (9)(b)(v), chapter 462, Laws of 1993,~~)) RCW 48.94.030 (9)(b)(v) is the lesser of fifty thousand dollars or an amount set by the reinsurer.

NEW SECTION

WAC 284-13-750 Reporting of discipline in another jurisdiction. A reinsurance intermediary, or a pending applicant, must notify the commissioner within fifteen business days of a disciplinary action taken against it by another governmental jurisdiction.

NEW SECTION

WAC 284-13-760 Reporting of a felony conviction. A person holding a reinsurance intermediary license, or a pending applicant, convicted of any felony involving dishonesty or a breach of trust, or convicted of an offense under the Violent Crime Control and Law Enforcement Act of 1994 (108 Stat. 2115; 18 U.S.C. Sec. 1033) must notify the commissioner of the conviction within fifteen business days after the conviction.

WSR 09-20-068
PROPOSED RULES
HORSE RACING COMMISSION

[Filed October 5, 2009, 8:39 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 09-15-117.

Title of Rule and Other Identifying Information: WAC 260-36-220 Additional premiums for stalls and horses started and 260-36-230 Short duration industrial insurance coverage.

Hearing Location(s): Auburn City Council Chambers, 25 West Main, Auburn, WA 98002, on November 12, 2009, at 9:30 a.m.

Date of Intended Adoption: November 12, 2009.

Submit Written Comments to: Robert J. Lopez, 6326 Martin Way, Suite 209, Olympia, WA 98516-5578, e-mail rlopez@whrc.state.wa.us, fax (360) 459-6461, by November 2, 2009.

Assistance for Persons with Disabilities: Contact Patty Sorby by November 2, 2009, TTY (360) 459-6462.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: WAC 260-36-220: (1) To amend this section to clarify how exercise rider premiums are determined at Class A, B and C tracks; (2) to eliminate the current per twelve horse calculation and set premiums based upon each horse in training (stalled at a Class A or B track or started at a Class C track); and (3) to clarify the trainer's responsibility to maintain records and to accurate [accurately] report the number of horses, which would required [require] the trainer to pay additional industrial insurance premiums to cover licensed exercise riders.

WAC 260-36-230, to exclude the industrial insurance premiums for exercise riders from the short duration exception to the requirement to pay full coverage. In other words, a trainer who obtains short duration industrial insurance coverage, still must pay the full premiums required to cover exercise riders.

Reasons Supporting Proposal: RCW 67.16.020.

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

Name of Proponent: Washington horse racing commission, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation and Enforcement: Robert J. Lopez, 6326 Martin Way, Suite 209, Olympia, WA 98516-5578, (360) 459-6462.

No small business economic impact statement has been prepared under chapter 19.85 RCW. Not applicable.

A cost-benefit analysis is not required under RCW 34.05.328. Not applicable.

October 5, 2009
R. J. Lopez
Executive Secretary

AMENDATORY SECTION (Amending WSR 08-05-087, filed 2/15/08, effective 3/17/08)

WAC 260-36-220 Industrial insurance premiums—Additional premiums for ((~~stalls and horses started~~)) exercise riders. (1) At the time of licensing, and as provided in this section, a trainer must pay ((~~all~~)) the annual industrial insurance premiums for exercise riders established by labor and industries, unless exempted under WAC 260-36-240.

(2)(a) A trainer at a Class A or B track must pay all required annual industrial insurance premiums ((~~based upon the number of stalls the trainer has~~)) for exercise riders equal to the maximum number of horses in training on any given day during the calendar year that the trainer has both on and off the grounds of a racing association. ((~~All trainers at a Class A or B track are required to pay at least one stall premium at the time of licensing. As to stalls off the grounds of a racing association, a trainer must count all stalls that are used for horses subject to being ridden by licensed exercise riders employed by the trainer, if the exercise riders are to be covered by Washington labor and industries industrial insurance under the horse industry account.~~))

(b) ((~~The calculations for number of stalls will be based upon stalls allotted by the racing association.~~

~~(c) The number of stall premiums that a trainer is required to pay will be determined as follows:~~

~~(i) For zero to twelve stalls a trainer must pay for one stall premium;~~

~~(ii) For thirteen to twenty-four stalls a trainer must pay for two stall premiums;~~

~~(iii) For twenty-five to thirty-six stalls a trainer must pay for three stall premiums; and~~

~~(iv) For thirty-seven or more stalls a trainer must pay for four stall premiums.~~)) For horses on the grounds of a Class A or B track, a trainer must count stalls that are occupied by horses under the trainer's care. Premiums will be calculated on the total number of stalls allotted by the racing association, even if the horse is stalled on the grounds for a day or less. (For example, if a trainer comes to Washington to enter or nominate his/her horse in one race and the horse is only on the grounds for one day, the trainer is required to pay the full industrial insurance premium for that one horse.) Stalls assigned for pony horses will not be counted.

(c) For horses off the grounds, a trainer must count all horses in training that are subject to being ridden by licensed exercise riders, if the exercise riders are to be covered by the Washington labor and industries insurance under the horse industry account.

(d) If any trainer increases the number of ((~~stalls~~)) horses in training or racing, either on or off the grounds((~~,~~)) during the ((~~license~~)) calendar year, the trainer is responsible to pay the additional ((~~stall~~)) premiums ((~~owed~~)) as provided in this section.

(e) If any trainer decreases the number of horses in training or racing, either on or off the grounds during the calendar year, the trainer is not entitled to any refund as premiums are annual fees that are not prorated and are assessed on the maximum number of horses in training on any day during the calendar year.

(f) It is the trainer's responsibility to maintain records and accurately report the number of horses in training (both on and off the grounds) for purposes of paying industrial insurance premiums required by this section. Any time during the calendar year if a trainer increases the number of horses in training or racing beyond the premium previously assessed the trainer is responsible for immediately reporting and paying the additional premium owed.

(3)(a) A trainer at a Class C track must pay industrial insurance ((~~horse-start~~)) premiums ((~~based upon the~~)) for exercise riders equal to the maximum number of different horses the trainer starts at the Class C tracks during the calendar year, or the maximum number of horses the trainer has in training, whichever is greater. All trainers at a Class C track are required to pay industrial insurance for at least one ((~~horse-start premium~~)) horse.

(b) ((~~The number of horse start premiums a trainer is required to pay will be determined as follows:~~

~~(i) For zero to twelve different horses started, a trainer must pay for one horse-start premium;~~

~~(ii) For thirteen to twenty-four different horses started, a trainer must pay for two horse-start premiums;~~

~~(iii) For twenty-five to thirty-six different horses started, a trainer must pay for three horse-start premiums; and~~

~~(iv) For thirty-seven or more different horses started, a trainer must pay for four horse-start premiums.~~

~~(e)~~)) If((,)) during the calendar year((,)) a horse is started by more than one trainer((,)) that horse will count as a different horse for each trainer for the purpose of calculating the number of horse-start premiums required.

(((~~d~~))) (c) It is the ((~~trainer is responsible~~)) trainer's responsibility to maintain ((~~their~~)) records ((~~of~~)) and accurately report the number of different horses started((~~, and to pay the additional horse-start premiums owed, when they~~)) or in training for the purpose of paying industrial insurance premiums required in this section. Any time during the calendar year if a trainer increases the number of different horses started ((~~in a race as described in this section~~)) or the total number of horses in training beyond the premium previously assessed the trainer is responsible for immediately reporting and paying the additional premium owed.

AMENDATORY SECTION (Amending WSR 08-05-087, filed 2/15/08, effective 3/17/08)

WAC 260-36-230 Short duration industrial insurance coverage. (1) Trainers entering horses to run in Washington races will be allowed to obtain short duration industrial insurance coverage ((~~under the following~~)) that will reduce the trainer's base premium and the groom and/or assistant trainer slot(s). The reduced premiums for short duration coverage will not apply to the additional premiums required to cover exercise riders as provided in WAC 260-36-220. The following conditions will apply for short duration coverage:

(a) Trainers who ship in to Class A or B race meets may purchase short duration industrial insurance coverage for seven consecutive calendar days. The trainer must pay twenty percent of the trainer base premium, and twenty percent for each groom slot or assistant trainer slot obtained((~~, assistant trainer hired, and each industrial insurance stall premium as required in WAC 260-36-220~~)) (all rounded to the next whole dollar). The base premium used for this calculation will be the industrial insurance premiums established for Class A or B race meets. A trainer may only purchase Class A or B race meet short duration coverage for three seven-day periods per calendar year.

(b) Trainers who ship in to Class C race meets may purchase short duration industrial insurance coverage for seven consecutive calendar days. The trainer must pay twenty percent of the trainer base premium, and twenty percent of each groom slot or assistant trainer slot obtained((~~, assistant trainer hired, and each industrial insurance horse-start premium as required in WAC 260-36-220~~)) (all rounded to the next whole dollar). The base premium used for this calculation will be the industrial insurance premiums established for Class C race meets. A trainer may only purchase Class C race meet short duration coverage for three seven-day periods per calendar year. Class C race meet short duration industrial insurance coverage is not transferable to a Class A or B race meet.

(2) Before short duration coverage will be allowed, a trainer must obtain a license and pay all applicable license and fingerprint fees required in WAC 260-36-085. The trainer is also required to ensure that each groom, assistant trainer, pony rider, and exercise rider hired by the trainer has a proper license. A trainer may only employ persons on the grounds of the racing association who are properly licensed by the commission.

WSR 09-20-071
PROPOSED RULES
BOARD FOR VOLUNTEER FIREFIGHTERS AND RESERVE OFFICERS

[Filed October 5, 2009, 9:31 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 09-14-022.

Title of Rule and Other Identifying Information: Actuarial tables, schedules, and factors.

Hearing Location(s): Board for Volunteer Firefighters and Reserve Officers, James R. Larson Forum Building, 605 11th Avenue S.E., Suite #207, Olympia, WA 98501, on November 20, 2009, at 10:00 a.m.

Date of Intended Adoption: November 20, 2009.

Submit Written Comments to: Brigette K. Smith, P.O. Box 114, Olympia, WA 98507, e-mail brigettes@bvff.wa.gov, fax (360) 586-1987, by November 13, 2009.

Assistance for Persons with Disabilities: Contact Brigette K. Smith by November 13, 2009, TTY (360) 753-7318.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Amending chapter 491-02 WAC to adopt new actuarial tables for use in calculating joint survivor pensions, survivor pensions, and lump sum settlements to reflect the latest actuarial study and the changes in mortality rates.

Reasons Supporting Proposal: New tables produced by the office of the state actuary based upon new mortality rates.

Statutory Authority for Adoption: RCW 41.24.290(2).

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

Name of Proponent: Board for volunteer firefighters and reserve officers, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation and Enforcement: Brigette K. Smith, 605 11th Avenue East, Suite #112, Olympia, WA 98501, (360) 753-7318.

No small business economic impact statement has been prepared under chapter 19.85 RCW. There is no impact to small businesses.

A cost-benefit analysis is not required under RCW 34.05.328. Relates only to internal governmental operations RCW 34.05.328 (5)(b)(ii).

October 5, 2009
Brigette K. Smith
Executive Secretary

AMENDATORY SECTION (Amending WSR 03-22-024, filed 10/27/03, effective 1/1/04)

WAC 491-02-095 Actuarial tables, schedules, and factors. This chapter contains the tables, schedules, and factors adopted by the board for volunteer firefighters and reserve officers pursuant to the authority granted by RCW 41.24.185 for calculating optional retirement allowances of members of retirement systems administered by the board. These tables, schedules, and factors were adopted by the board upon the recommendation of and in light of the findings of the state actuary in his regular actuarial investigation into the mortality, service, compensation, and other experience of the members and beneficiaries of such retirement systems. The tables, schedules, and factors contained in this chapter shall govern the retirement allowances only of members retiring during the period from January 1, ((~~2004~~)) 2010, until such time as these tables, schedules, and factors are amended by the board following the next actuarial investigation conducted by the state actuary. The retirement allowances of members retiring before January 1, ((~~2004~~)) 2010, shall continue to be governed by the tables, schedules, and factors in effect at the time of each member's retirement. Any new tables, schedules, and factors adopted by the board in the future shall govern retirement allowances only of members retiring after the adoption of such new tables, schedules, and factors.

Board for Volunteer Firefighters and Reserve Officers
Table #1
Joint/Survivor Pension
Option 2 (Joint and 100% Survivor Pension with Pop-up)
(WAC 415-02-380)

Member Younger		Member Older	
Age Difference	Option 2 100%	Age Difference	Option 2 100%
-20	((~~0.958~~)) 0.937	0	((~~0.870~~)) 0.835
-19	((~~0.955~~)) 0.933	1	((~~0.862~~)) 0.829
-18	((~~0.952~~)) 0.929	2	((~~0.857~~)) 0.823
-17	((~~0.949~~)) 0.925	3	((~~0.844~~)) 0.818
-16	((~~0.947~~)) 0.921	4	((~~0.840~~)) 0.812
-15	((~~0.944~~)) 0.916	5	((~~0.836~~)) 0.807
-14	((~~0.940~~)) 0.912	6	((~~0.831~~)) 0.801
-13	((~~0.937~~)) 0.907	7	((~~0.818~~)) 0.796
-12	((~~0.934~~)) 0.902	8	((~~0.814~~)) 0.791
-11	((~~0.930~~)) 0.897	9	((~~0.809~~)) 0.786
-10	((~~0.927~~)) 0.892	10	((~~0.805~~)) 0.781
-9	((~~0.923~~)) 0.886	11	((~~0.802~~)) 0.776
-8	((~~0.920~~)) 0.881	12	((~~0.787~~)) 0.771
-7	((~~0.916~~)) 0.875	13	((~~0.784~~)) 0.767
-6	((~~0.912~~)) 0.870	14	((~~0.780~~)) .762
-5	((~~0.908~~)) 0.864	15	((~~0.777~~)) 0.758
-4	((~~0.901~~)) 0.858	16	((~~0.773~~)) 0.754
-3	((~~0.896~~)) 0.852	17	((~~0.770~~)) 0.750
-2	((~~0.889~~)) 0.847	18	((~~0.767~~)) 0.746
-1	((~~0.879~~)) 0.841	19	((~~0.764~~)) 0.743
		20	((~~0.762~~)) 0.739
		21	((~~0.759~~)) 0.736
		22	((~~0.756~~)) 0.733
		23	((~~0.754~~)) 0.730
		24	((~~0.752~~)) 0.727
		25	((~~0.750~~)) 0.725
		26	((~~0.748~~)) 0.722
		27	((~~0.746~~)) 0.720
		28	((~~0.744~~)) 0.717
		29	((~~0.743~~)) 0.715
		30	((~~0.741~~)) 0.713
		31	((~~0.740~~)) 0.711
		32	((~~0.738~~)) 0.709

Member Younger		Member Older	
Age Difference	Option 2 100%	Age Difference	Option 2 100%
		33	((~~0.737~~)) 0.708
		34	((~~0.736~~)) 0.706
		35	((~~0.735~~)) 0.705
		36	((~~0.734~~)) 0.703
		37	((~~0.733~~)) 0.702
		38	((~~0.732~~)) 0.700
		39	((~~0.731~~)) 0.699
		40	((~~0.730~~)) 0.698

Table #2
Survivor Pension
Early Retirement Factors
(WAC 415-02-320)

Years Early	Month 0	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11
((~~0~~	~~1.0000~~	~~0.9933~~	~~0.9866~~	~~0.9799~~	~~0.9732~~	~~0.9665~~	~~0.9598~~	~~0.9531~~	~~0.9464~~	~~0.9397~~	~~0.9330~~	~~0.9263~~
~~1~~	~~0.9200~~	~~0.9133~~	~~0.9066~~	~~0.8999~~	~~0.8932~~	~~0.8865~~	~~0.8798~~	~~0.8731~~	~~0.8664~~	~~0.8597~~	~~0.8530~~	~~0.8463~~
~~2~~	~~0.8400~~	~~0.8333~~	~~0.8266~~	~~0.8199~~	~~0.8132~~	~~0.8065~~	~~0.7998~~	~~0.7931~~	~~0.7864~~	~~0.7797~~	~~0.7730~~	~~0.7663~~
~~3~~	~~0.7600~~	~~0.7558~~	~~0.7516~~	~~0.7474~~	~~0.7432~~	~~0.7390~~	~~0.7348~~	~~0.7306~~	~~0.7264~~	~~0.7222~~	~~0.7180~~	~~0.7138~~
~~4~~	~~0.7100~~	~~0.7058~~	~~0.7016~~	~~0.6974~~	~~0.6932~~	~~0.6890~~	~~0.6848~~	~~0.6806~~	~~0.6764~~	~~0.6722~~	~~0.6680~~	~~0.6638~~
~~5~~	~~0.6600~~	~~0.6558~~	~~0.6516~~	~~0.6474~~	~~0.6432~~	~~0.6390~~	~~0.6348~~	~~0.6306~~	~~0.6264~~	~~0.6222~~	~~0.6180~~	~~0.6138~~
~~6~~	~~0.6100~~	~~0.6058~~	~~0.6016~~	~~0.5974~~	~~0.5932~~	~~0.5890~~	~~0.5848~~	~~0.5806~~	~~0.5764~~	~~0.5722~~	~~0.5680~~	~~0.5638~~
~~7~~	~~0.5600~~	~~0.5558~~	~~0.5516~~	~~0.5474~~	~~0.5432~~	~~0.5390~~	~~0.5348~~	~~0.5306~~	~~0.5264~~	~~0.5222~~	~~0.5180~~	~~0.5138~~
~~8~~	~~0.5100~~	~~0.5067~~	~~0.5034~~	~~0.5001~~	~~0.4968~~	~~0.4935~~	~~0.4902~~	~~0.4869~~	~~0.4836~~	~~0.4803~~	~~0.4770~~	~~0.4737~~
~~9~~	~~0.4700~~	~~0.4667~~	~~0.4634~~	~~0.4601~~	~~0.4568~~	~~0.4535~~	~~0.4502~~	~~0.4469~~	~~0.4436~~	~~0.4403~~	~~0.4370~~	~~0.4337~~
~~10~~	~~0.4300~~	~~0.4267~~	~~0.4234~~	~~0.4201~~	~~0.4168~~	~~0.4135~~	~~0.4102~~	~~0.4069~~	~~0.4036~~	~~0.4003~~	~~0.3970~~	~~0.3937~~
~~11~~	~~0.3900~~	~~0.3867~~	~~0.3834~~	~~0.3801~~	~~0.3768~~	~~0.3735~~	~~0.3702~~	~~0.3669~~	~~0.3636~~	~~0.3603~~	~~0.3570~~	~~0.3537~~
~~12~~	~~0.3500~~	~~0.3467~~	~~0.3434~~	~~0.3401~~	~~0.3368~~	~~0.3335~~	~~0.3302~~	~~0.3269~~	~~0.3236~~	~~0.3203~~	~~0.3170~~	~~0.3137~~
~~13~~	~~0.3100~~	~~0.3083~~	~~0.3066~~	~~0.3049~~	~~0.3032~~	~~0.3015~~	~~0.2998~~	~~0.2981~~	~~0.2964~~	~~0.2947~~	~~0.2930~~	~~0.2913~~
~~14~~	~~0.2900~~	~~0.2883~~	~~0.2866~~	~~0.2849~~	~~0.2832~~	~~0.2815~~	~~0.2798~~	~~0.2781~~	~~0.2764~~	~~0.2747~~	~~0.2730~~	~~0.2713~~
~~15~~	~~0.2700~~	~~0.2683~~	~~0.2666~~	~~0.2649~~	~~0.2632~~	~~0.2615~~	~~0.2598~~	~~0.2581~~	~~0.2564~~	~~0.2547~~	~~0.2530~~	~~0.2513~~
~~16~~	~~0.2500~~	~~0.2483~~	~~0.2466~~	~~0.2449~~	~~0.2432~~	~~0.2415~~	~~0.2398~~	~~0.2381~~	~~0.2364~~	~~0.2347~~	~~0.2330~~	~~0.2313~~
~~17~~	~~0.2300~~	~~0.2283~~	~~0.2266~~	~~0.2249~~	~~0.2232~~	~~0.2215~~	~~0.2198~~	~~0.2181~~	~~0.2164~~	~~0.2147~~	~~0.2130~~	~~0.2113~~
~~18~~	~~0.2100~~	~~0.2092~~	~~0.2084~~	~~0.2076~~	~~0.2068~~	~~0.2060~~	~~0.2052~~	~~0.2044~~	~~0.2036~~	~~0.2028~~	~~0.2020~~	~~0.2012~~
~~19~~	~~0.2000~~	~~0.1992~~	~~0.1984~~	~~0.1976~~	~~0.1968~~	~~0.1960~~	~~0.1952~~	~~0.1944~~	~~0.1936~~	~~0.1928~~	~~0.1920~~	~~0.1912~~
~~20~~	~~0.1900~~	~~0.1892~~	~~0.1884~~	~~0.1876~~	~~0.1868~~	~~0.1860~~	~~0.1852~~	~~0.1844~~	~~0.1836~~	~~0.1828~~	~~0.1820~~	~~0.1812~~
~~21~~	~~0.1800~~	~~0.1792~~	~~0.1784~~	~~0.1776~~	~~0.1768~~	~~0.1760~~	~~0.1752~~	~~0.1744~~	~~0.1736~~	~~0.1728~~	~~0.1720~~	~~0.1712~~
~~22~~	~~0.1700~~	~~0.1692~~	~~0.1684~~	~~0.1676~~	~~0.1668~~	~~0.1660~~	~~0.1652~~	~~0.1644~~	~~0.1636~~	~~0.1628~~	~~0.1620~~	~~0.1612~~
~~23~~	~~0.1600~~	~~0.1592~~	~~0.1584~~	~~0.1576~~	~~0.1568~~	~~0.1560~~	~~0.1552~~	~~0.1544~~	~~0.1536~~	~~0.1528~~	~~0.1520~~	~~0.1512~~
~~24~~	~~0.1500~~	~~0.1492~~	~~0.1484~~	~~0.1476~~	~~0.1468~~	~~0.1460~~	~~0.1452~~	~~0.1444~~	~~0.1436~~	~~0.1428~~	~~0.1420~~	~~0.1412~~
~~25~~	~~0.1400~~	~~0.1392~~	~~0.1384~~	~~0.1376~~	~~0.1368~~	~~0.1360~~	~~0.1352~~	~~0.1344~~	~~0.1336~~	~~0.1328~~	~~0.1320~~	~~0.1312~~
~~26~~	~~0.1300~~	~~0.1292~~	~~0.1284~~	~~0.1276~~	~~0.1268~~	~~0.1260~~	~~0.1252~~	~~0.1244~~	~~0.1236~~	~~0.1228~~	~~0.1220~~	~~0.1212~~

Years Early	Month 0	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11
~~27~~	~~0.1200~~	~~0.1192~~	~~0.1184~~	~~0.1176~~	~~0.1168~~	~~0.1160~~	~~0.1152~~	~~0.1144~~	~~0.1136~~	~~0.1128~~	~~0.1120~~	~~0.1112~~
~~28~~	~~0.1100~~	~~0.1092~~	~~0.1084~~	~~0.1076~~	~~0.1068~~	~~0.1060~~	~~0.1052~~	~~0.1044~~	~~0.1036~~	~~0.1028~~	~~0.1020~~	~~0.1012~~
~~29+~~	~~0.1000~~	~~0.1000~~	~~0.1000~~	~~0.1000~~	~~0.1000~~	~~0.1000~~	~~0.1000~~	~~0.1000~~	~~0.1000~~	~~0.1000~~	~~0.1000~~	~~0.1000~~))
0	1.0000	0.9922	0.9844	0.9766	0.9688	0.9610	0.9532	0.9454	0.9376	0.9298	0.9220	0.9142
1	0.9060	0.8991	0.8922	0.8853	0.8784	0.8715	0.8646	0.8577	0.8508	0.8439	0.8370	0.8301
2	0.8230	0.8168	0.8106	0.8044	0.7982	0.7920	0.7858	0.7796	0.7734	0.7672	0.7610	0.7548
3	0.7490	0.7435	0.7380	0.7325	0.7270	0.7215	0.7160	0.7105	0.7050	0.6995	0.6940	0.6885
4	0.6830	0.6781	0.6732	0.6683	0.6634	0.6585	0.6536	0.6487	0.6438	0.6389	0.6340	0.6291
5	0.6240	0.6195	0.6150	0.6105	0.6060	0.6015	0.5970	0.5925	0.5880	0.5835	0.5790	0.5745
6	0.5700	0.5660	0.5620	0.5580	0.5540	0.5500	0.5460	0.5420	0.5380	0.5340	0.5300	0.5260
7	0.5220	0.5184	0.5148	0.5112	0.5076	0.5040	0.5004	0.4968	0.4932	0.4896	0.4860	0.4824
8	0.4790	0.4758	0.4726	0.4694	0.4662	0.4630	0.4598	0.4566	0.4534	0.4502	0.4470	0.4438
9	0.4400	0.4371	0.4342	0.4313	0.4284	0.4225	0.4226	0.4197	0.4168	0.4139	0.4110	0.4081
10	0.4050	0.4023	0.3996	0.3969	0.3942	0.3915	0.3888	0.3861	0.3834	0.3807	0.3780	0.3753
11	0.3730	0.3705	0.3680	0.3655	0.3630	0.3605	0.3580	0.3555	0.3530	0.3505	0.3480	0.3455
12	0.3430	0.3408	0.3386	0.3364	0.3342	0.3320	0.3298	0.3276	0.3254	0.3232	0.3210	0.3188
13	0.3170	0.3149	0.3128	0.3107	0.3086	0.3065	0.3044	0.3023	0.3002	0.2981	0.2960	0.2939
14	0.2920	0.2902	0.2884	0.2866	0.2848	0.2830	0.2812	0.2794	0.2276	0.2758	0.2740	0.2722
15	0.2700	0.2683	0.2666	0.2649	0.2632	0.2615	0.2598	0.2581	0.2564	0.2547	0.2530	0.2513
16	0.2500	0.2484	0.2468	0.2452	0.2436	0.2420	0.2404	0.2388	0.2372	0.2356	0.2340	0.2324
17	0.2310	0.2296	0.2282	0.2268	0.2254	0.2240	0.2226	0.2212	0.2198	0.2184	0.2170	0.2156
18	0.2140	0.2127	0.2114	0.2101	0.2088	0.2075	0.2062	0.2049	0.2036	0.2023	0.2010	0.1997
19	0.1980	0.1968	0.1956	0.1944	0.1932	0.1920	0.1908	0.1896	0.1884	0.1872	0.1860	0.1848
20	0.1840	0.1828	0.1816	0.1804	0.1792	0.1780	0.1768	0.1756	0.1744	0.1732	0.1720	0.1708
21	0.1700	0.1690	0.1680	0.1670	0.1660	0.1650	0.1640	0.1630	0.1620	0.1610	0.1600	0.1590
22	0.1580	0.1571	0.1562	0.1553	0.1544	0.1535	0.1526	0.1517	0.1508	0.1499	0.1490	0.1481
23	0.1470	0.1461	0.1452	0.1443	0.1434	0.1425	0.1416	0.1407	0.1398	0.1389	0.1380	0.1371
24	0.1360	0.1352	0.1344	0.1336	0.1328	0.1320	0.1312	0.1304	0.1296	0.1288	0.1280	0.1272
25	0.1260	0.1253	0.1246	0.1239	0.1232	0.1225	0.1218	0.1211	0.1204	0.1197	0.1190	0.1183
26	0.1180	0.1173	0.1166	0.1159	0.1152	0.1145	0.1138	0.1131	0.1124	0.1117	0.1110	0.1103
27	0.1090	0.1084	0.1078	0.1072	0.1066	0.1060	0.1054	0.1048	0.1042	0.1036	0.1030	0.1024
28	0.1020	0.1018	0.1016	0.1014	0.1012	0.1010	0.1008	0.1006	0.1004	0.1002	0.1000	0.1000
29+	0.1000	0.1000	0.1000	0.1000	0.1000	0.1000	0.1000	0.1000	0.1000	0.1000	0.1000	0.1000

Table #3
Lump-Sum Settlements

Age	Factor	Age	Factor
20	((~~12.7335330~~)) 14.3791	60	((~~10.0726845~~)) 11.0834
21	((~~12.7191510~~)) 14.3576	61	((~~9.9030688~~)) 10.8849
22	((~~12.7036393~~)) 14.3347	62	((~~9.7274751~~)) 10.6795
23	((~~12.6870065~~)) 14.3104	63	((~~9.5462842~~)) 10.4675
24	((~~12.6688761~~)) 14.2845	64	((~~9.3601408~~)) 10.2498
25	((~~12.6496453~~)) 14.2570	65	((~~9.1682895~~)) 10.0267
26	((~~12.6287501~~)) 14.2277	66	((~~8.9710880~~)) 9.7975
27	((~~12.6062073~~)) 14.1965	67	((~~8.7693452~~)) 9.5633
28	((~~12.5820349~~)) 14.1633	68	((~~8.5617611~~)) 9.3247
29	((~~12.5558736~~)) 14.1277	69	((~~8.3481095~~)) 9.0792
30	((~~12.5281256~~)) 14.0898	70	((~~8.1282574~~)) 8.8273
31	((~~12.4982502~~)) 14.0495	71	((~~7.9049634~~)) 8.5679
32	((~~12.4666517~~)) 14.0068	72	((~~7.7673880~~)) 8.3037
33	((~~12.4331717~~)) 13.9619	73	((~~7.4434669~~)) 8.0334
34	((~~12.3976573~~)) 13.9146	74	((~~7.2070202~~)) 7.7574
35	((~~12.3601450~~)) 13.8648	75	((~~6.9674370~~)) 7.4768
36	((~~12.3203083~~)) 13.8125	76	((~~6.7250943~~)) 7.1936

Age	Factor	Age	Factor
37	((~~12.2778326~~)) 13.7574	77	((~~6.4800919~~)) 6.9075
38	((~~12.2327750~~)) 13.6993	78	((~~6.2326266~~)) 6.6205
39	((~~12.1844828~~)) 13.6378	79	((~~5.9832374~~)) 6.3331
40	((~~12.1332130~~)) 13.5726	80	((~~5.7325776~~)) 6.0460
41	((~~12.0783450~~)) 13.5034	81	((~~5.4813743~~)) 5.7603
42	((~~12.0199820~~)) 13.4300	82	((~~5.2319096~~)) 5.4770
43	((~~11.9577175~~)) 13.3520	83	((~~4.9851840~~)) 5.2000
44	((~~11.8915114~~)) 13.2693	84	((~~4.7422313~~)) 4.9276
45	((~~11.8211694~~)) 13.1816	85	((~~4.5041150~~)) 4.6629
46	((~~11.7461884~~)) 13.0887	86	((~~4.2722117~~)) 4.4045
47	((~~11.6665967~~)) 12.9903	87	((~~4.0482355~~)) 4.1524
48	((~~11.5816343~~)) 12.8860	88	((~~3.8341147~~)) 3.9110
49	((~~11.4912414~~)) 12.7754	89	((~~3.6319683~~)) 3.6829
50	((~~11.3949206~~)) 12.6582	90	((~~3.4438535~~)) 3.4668
51	((~~11.2923916~~)) 12.5339	91	((~~3.2716047~~)) 3.2679
52	((~~11.1841811~~)) 12.4021	92	((~~3.1136352~~)) 3.0850
53	((~~11.0693428~~)) 12.2638	93	((~~2.9700277~~)) 2.9184
54	((~~10.9474827~~)) 12.1178	94	((~~2.8403701~~)) 2.7652
55	((~~10.8184363~~)) 11.9639	95	((~~2.7238456~~)) 2.6233
56	((~~10.6826650~~)) 11.8019	96	((~~2.6193178~~)) 2.4971
57	((~~10.5407844~~)) 11.6327	97	((~~2.5253520~~)) 2.3819
58	((~~10.3917265~~)) 11.4573	98	((~~2.4401933~~)) 2.2755
59	((~~10.2356241~~)) 11.2742	99	((~~2.3616744~~)) 2.1823

WSR 09-20-083
WITHDRAWAL OF PROPOSED RULES
SOUTH PUGET SOUND COMMUNITY COLLEGE
[Filed October 6, 2009, 1:11 p.m.]

In compliance with RCW 34.05.335, South Puget Sound Community College is giving notice to the office of the code reviser to withdraw a notice of proposed rule making previously filed as WSR 09-18-114, on September 2, 2009. A notice of proposed rule making will be filed at a later date.

Gerald Pumphrey
President

WSR 09-20-091
PROPOSED RULES
DEPARTMENT OF HEALTH
(Board of Osteopathic Medicine and Surgery)
[Filed October 6, 2009, 4:57 p.m.]

Original Notice.

Exempt from preproposal statement of inquiry under RCW 34.05.310(4).

Title of Rule and Other Identifying Information: WAC 246-853-135, amending the time period for a temporary practice permit.

Hearing Location(s): St. Francis Hospital, Education Room, 34515 9th Avenue South, Federal Way, WA 98003, on November 20, 2009, at 9:00 a.m.

Date of Intended Adoption: November 20, 2009.

Submit Written Comments to: Erin Obenland, Program Manager, Department of Health, Board of Osteopathic Medicine and Surgery, P.O. Box 47852, Olympia, WA 98504-7852, web site http://www3.doh.wa.gov/policyreview/, fax (360) 236-2406, by November 13, 2009.

Assistance for Persons with Disabilities: Contact Erin Obenland by November 13, 2009, TTY (800) 833-6388 or 711.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposed rule amends the current temporary practice permit rule WAC 246-853-135 to allow more time for a fingerprint-based national background check to be completed. The national background check process is lengthy and has caused licensing delays that may affect the public's access to health care. Currently, the temporary practice permit expires upon issuance of a license by the board or ninety days after issuance of the temporary permit, which may not allow enough time to process background checks. The amendment extends the expiration timeframe of the temporary practice permit from ninety days to one hundred eighty days, which is consistent with secretary profession, medical commission, and nursing commission rules.

Reasons Supporting Proposal: In 2008 4SHB 1103 (chapter 134, Laws of 2008) passed authorizing fingerprint-based national background checks for those situations when a background check in RCW 18.130.64 [18.13.064] is not adequate. This rule amendment would reduce instances of temporary practice permits expiring for out-of-state applicants

who are waiting while fingerprint-based national background checks are completed. This would be a benefit so there is no break in the time when an osteopathic physician can provide care to the public.

Statutory Authority for Adoption: RCW 18.57.005, 18.130.075.

Statute Being Implemented: Chapter 18.57 RCW, RCW 18.130.075.

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

Name of Proponent: Washington state board of osteopathic medicine and surgery, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation and Enforcement: Erin Obenland, 310 Israel Road S.E., Tumwater, WA 98501, (360) 236-4945.

No small business economic impact statement has been prepared under chapter 19.85 RCW. Under RCW 19.85.025 and 34.05.310 (4)(g)(ii), a small business economic impact statement is not required for proposed rules that adopt, amend, or repeal a filing or related process requirement for applying to an agency for a license or permit.

A cost-benefit analysis is not required under RCW 34.05.328. RCW 34.05.328 (5)(b)(v) exempts rules the content of which is explicitly and specifically dictated by statute.

October 6, 2009
Blake T. Maresh
Executive Director

AMENDATORY SECTION (Amending Order 303B, filed 9/23/92, effective 10/24/92)

WAC 246-853-135 Temporary practice permit. A temporary permit to practice osteopathic medicine and surgery may be issued to an individual licensed in another state that has substantially equivalent licensing standards to those in Washington.

(1) The temporary permit may be issued upon receipt of:

(a) Documentation from the reciprocal state that the licensing standards used for issuing the license are substantially equivalent to the current Washington licensing standards;

(b) A completed application form on which the applicant indicates he or she wishes to receive a temporary permit and application and temporary permit fees;

(c) Verification of all state licenses, whether active or inactive, indicating that the applicant is not subject to charges or disciplinary action for unprofessional conduct or impairment;

(d) Verification from the federation of state medical board's disciplinary action data bank that the applicant has not been disciplined by a state board or federal agency.

(2) A temporary practice permit grants the individual the full scope to practice osteopathic medicine and surgery.

(3) The temporary permit shall expire upon issuance of a license by the board or ((~~ninety~~)) one hundred eighty days after issuance of the temporary permit, whichever occurs first. The applicant must not be subject to denial of a license or issuance of a conditional license under this chapter.

((~~(3)~~)) (4) A temporary permit shall be issued only once to each applicant. An applicant who does not complete the application process shall not receive a subsequent temporary permit.

WSR 09-20-096
PROPOSED RULES
EMPLOYMENT SECURITY DEPARTMENT

[Filed October 7, 2009, 9:07 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 09-16-011.

Title of Rule and Other Identifying Information: WAC 192-320-035 How are unemployment insurance tax rates determined for employers who are delinquent on taxes?

Hearing Location(s): Employment Security Department, Maple Leaf Conference Room, 2nd Floor, 212 Maple Park, Olympia, WA, on November 10, 2009, at 10:30 a.m.

Date of Intended Adoption: November 16, 2009.

Submit Written Comments to: Pamela Ames, P.O. Box 9046, Olympia, WA 98507-9046, e-mail pames@esd.wa.gov, fax (360) 902-9799, by November 10, 2009.

Assistance for Persons with Disabilities: Contact Jeannette Nelson by November 9, 2009, TTY (360) 902-9569 or (360) 902-9602.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposed amendments implement HB 1338 (chapter 83, Laws of 2009). The new law broadens the ability of the commissioner of the employment security department to waive application of the higher tax rate for delinquent taxpayers if the employer acted in good faith and application of the higher tax rate would be inequitable.

Reasons Supporting Proposal: The rule provides standards for the commissioner to apply in determining whether to waive the higher tax rate for delinquent employers.

Statutory Authority for Adoption: RCW 50.12.010, 50.12.040, 50.29.010.

Statute Being Implemented: RCW 50.29.010.

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

Name of Proponent: Employment security department, governmental.

Name of Agency Personnel Responsible for Drafting: Art Wang, 212 Maple Park, Olympia, (360) 902-9587; Implementation and Enforcement: Nan Thomas, 212 Maple Park, Olympia, (360) 902-9303.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The proposed rule will not impose more than minor costs on businesses, nor will there be a disproportionate impact on small business. Any business costs associated with the rule are the result of the underlying legislation.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Juanita Myers, Employment Security Department, P.O. Box 9046, Olympia, WA 98507-9046,

phone (360) 902-9665, fax (360) 902-9799, e-mail jmyers@esd.wa.gov.

October 5, 2009
Paul Trause
Deputy Commissioner

AMENDATORY SECTION (Amending WSR 07-23-127, filed 11/21/07, effective 1/1/08)

WAC 192-320-035 How are unemployment insurance tax rates determined for employers who are delinquent on taxes or reports? (1) An employer that has not submitted by September 30 all reports, taxes, interest, and penalties required under Title 50 RCW for the period preceding July 1 of any year is not a "qualified employer."

(2) For purposes of this section, the department will disregard unpaid taxes, interest, and penalties if they constitute less than either one hundred dollars or one-half of one percent of the employer's total tax reported for the twelve-month period immediately preceding July 1. These minimum amounts only apply to taxes, interest, and penalties, not to failure to submit required reports.

(3)(a) This section does not apply ((~~to services under RCW 50.04.160 performed in domestic service in a private home, local college club, or local chapter of a college fraternity or sorority~~)) if the otherwise qualified ((~~domestic~~)) employer shows to the satisfaction of the commissioner that he or she acted in good faith and that application of the rate for delinquent taxes would be inequitable. This exception is to be narrowly construed to apply at the sole discretion of the commissioner, recognizing that the delinquent tax rate only applies after the employer has already received a grace period of not less than two months beyond the normal due date for reports and taxes due. The commissioner's decision shall be subject to review only under the arbitrary and capricious standard and shall be reversed only for manifest injustice based on clear and convincing evidence.

(b) Except for services under RCW 50.04.160 performed in domestic service in a private home, local college club, or local chapter of a college fraternity or sorority, the commissioner will not find that application of the rate for delinquent taxes would be inequitable:

(i) If the employer has been late with filing or with payment in more than one of the last eight consecutive quarters immediately preceding the applicable period;

(ii) If the delinquency was due to absences of key personnel and the absences were because of business trips, vacations, personnel turnover, or terminations;

(iii) If the delinquency was due to adjusting by more than two quarters the liable date when the employer first had employees; or

(iv) If the employer is a successor, the rate for delinquent taxes is based on the predecessor, and the successor could or should have determined the predecessor's tax status at the time of the transfer.

(c) Examples of when the commissioner may find that application of the rate for delinquent taxes would be inequitable include if the delinquency results from:

(i) An employer reducing its tax payment by the amount specified as a credit on the most recent account statement from the department, when the credit amount is later determined to be inaccurate;

(ii) Taxes due which are determined as the result of a voluntary audit;

(iii) Resolution of a pending appeal and any amounts due are paid within thirty days of the final resolution of the amount due;

(iv) The serious illness or death of key personnel or their family that extends throughout the period in which the tax could have been paid prior to September 30 and no reasonable alternative personnel were available and any amounts due are paid no later than December 31 of such year; or

(v) An employee or other contracted person committing fraud, embezzlement, theft, or conversion, the employer could not immediately detect or prevent the wrongful act, the employer had reasonable safeguards or internal controls in place, the employer filed a police report, and any amounts due are paid within thirty days of when the employer could reasonably have discovered the illegal act.

(d) When determining whether an employer acted in good faith and that application of the rate for delinquent taxes would be inequitable, the following factors are considered neutral and neither support nor preclude waiver of the rate for delinquent taxes:

(i) The harshness of the burden on the employer caused by application of the rate for delinquent taxes;

(ii) Lack of knowledge by the employer, bookkeepers, accountants, or other financial advisors about application of the law or the potential harshness of the rate;

(iii) Delay by the employer or its representative in opening mail or receiving other notice from the department; or

(iv) Error by a payroll, bookkeeping, or accounting service on behalf of an employer.

(4) The department shall provide notice to the employer or employer's agent that ((~~he or she~~)) the employer may be subject to the higher rate for delinquent taxes if the employer does not comply with this section. Notice may be in the form of an insert or statement in July, August, or September billing statements or in a letter or notice of assessment. Evidence of the routine practice of the department in mailing notice in billing statements or in a notice of assessment shall be sufficient to establish that the department provided this notice. No notice need be provided to an employer that is not currently registered and active.

(5) An employer that is not a "qualified employer" because of failure to pay contributions when due shall be assigned an array calculation factor rate two-tenths higher than that in rate class 40, unless the department approves a deferred payment contract with the employer by September 30 of the previous rate year. If an employer with an approved deferred payment contract fails to make any one of the payments or fails to submit any tax report and payment in a timely manner, the employer's tax rate shall immediately revert to an array calculation factor rate two-tenths higher than in rate class 40.

(6) An employer that is not a "qualified employer" because of failure to pay contributions when due shall be assigned a social cost factor rate in rate class 40.

(7) Assignment of the rate for delinquent taxes is not considered a penalty which is subject to waiver under WAC 192-310-030.

(8) The amendments to this section effective July 26, 2009, apply only to tax rates assigned after that date.

A cost-benefit analysis is not required under RCW 34.05.328. The proposed rule is not a significant legislative rule as defined in RCW 34.05.328.

October 5, 2009
Paul Trause
Deputy Commissioner

WSR 09-20-097
PROPOSED RULES
EMPLOYMENT SECURITY DEPARTMENT

[Filed October 7, 2009, 9:09 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 09-15-012.

Title of Rule and Other Identifying Information: New WAC 192-150-180 Quitting part-time work, which concerns the eligibility for unemployment benefits of certain individuals who voluntarily quit a part-time job.

Hearing Location(s): Employment Security Department, Maple Leaf Conference Room, 2nd Floor, 212 Maple Park, Olympia, WA, on November 10, 2009, at 10:00 a.m.

Date of Intended Adoption: November 16, 2009.

Submit Written Comments to: Pamela Ames, P.O. Box 9046, Olympia, WA 98507-9046, e-mail pames@esd.wa.gov, fax (360) 902-9799, by November 10, 2009.

Assistance for Persons with Disabilities: Contact Jeannette Nelson by November 9, 2009, TTY (360) 902-9569 or (360) 902-9602.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposed rule implements SB 5804 (chapter 247, Laws of 2009) providing that claimants who are simultaneously working both a full-time job and a part-time job will not be disqualified from receiving unemployment benefits solely because they quit the part-time job.

Reasons Supporting Proposal: The rule clarifies the circumstances under which the commissioner will determine that an individual who voluntarily quits a part-time job will not be disqualified from benefits.

Statutory Authority for Adoption: RCW 50.12.010, 50.12.040, 50.20.010.

Statute Being Implemented: RCW 50.20.050.

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

Name of Proponent: Employment security department, governmental.

Name of Agency Personnel Responsible for Drafting: Juanita Myers, 212 Maple Park, Olympia, (360) 902-9665; Implementation and Enforcement: Nan Thomas, 212 Maple Park, Olympia, (360) 902-9303.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The proposed rule will not impose more than minor costs on businesses, nor will there be a disproportionate impact on small business. Any business costs associated with the rule are the result of the underlying legislation.

NEW SECTION

WAC 192-150-180 Quitting part-time work—RCW 50.20.050(3). (1) **Effective date**. RCW 50.20.050(3) and this section apply to job separations that occur on or after July 26, 2009.

(2) **Definitions**. For purposes of this section:

(a) "Part-time work" means fewer than 35 hours of work per week.

(b) "Full-time work" means work of 35 or more hours per week.

(3) If you are simultaneously employed in a part-time job and a full-time job, you will not be denied benefits for quitting the part-time job under the following circumstances:

(a) You quit the part-time job before losing your full-time job;

(b) You did not know in advance that your full-time job would be ending; and

(c) You are eligible for benefits based on the separation from your full-time job.

(4) If you are denied benefits under RCW 50.20.050(3), the period of denial is the same as that under RCW 50.20.050 (2)(a). This means you will be denied for a period of seven weeks and until you earn at least seven times your weekly benefit amount in covered employment.

(5) **Examples**. The following are examples only and do not mean that the department would rule the same in similar situations.

(a) *You quit a part-time job two weeks before being laid off from your full-time job.* Benefits are allowed because you meet the criteria of subsection (3).

(b) *You quit a part-time job before the hours at your full-time job were reduced.* Benefits are allowed because you meet the criteria of subsection (3).

(c) *You quit a part-time job two weeks before the end of a temporary full-time job.* You had prior knowledge that the full-time job was ending. Benefits would be denied unless you had good cause for quitting the part-time job under RCW 50.20.050(2).

(d) *You quit a part-time job two weeks before being discharged from the full-time job.*

(i) If the separation from the full-time job was for misconduct, benefits would be denied for quitting the part-time job because you are not eligible for benefits based on the separation from the full-time job.

(ii) If the separation from the full-time job was not misconduct, benefits would be allowed because you meet the criteria of subsection (3).

(e) *You quit the part-time job and the full-time job on the same day.* The department will determine if you had good cause to quit both jobs under RCW 50.20.050(2).

(f) *You quit a part-time job but are still employed full-time at your other job.* The department will determine if you had good cause to quit under RCW 50.20.050(2).

WSR 09-20-098
PROPOSED RULES
EMPLOYMENT SECURITY DEPARTMENT

[Filed October 7, 2009, 9:12 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 09-14-007.

Title of Rule and Other Identifying Information: New sections in chapter 192-240 WAC relating to the payment of extended unemployment benefits: WAC 192-240-060 What is the priority of payments?, 192-240-070 What happens if I am paid emergency or extended benefits when I am eligible for a new claim?, and 192-240-080 How much will I receive in extended benefits if my regular weekly benefit amount is increased?

Hearing Location(s): Employment Security Department, Maple Leaf Conference Room, 2nd Floor, 212 Maple Park, Olympia, WA, on November 10, 2009, at 10:15 a.m.

Date of Intended Adoption: November 16, 2009.

Submit Written Comments to: Pamela Ames, P.O. Box 9046, Olympia, WA 98507-9046, e-mail pames@esd.wa.gov, fax (360) 902-9799, by November 10, 2009.

Assistance for Persons with Disabilities: Contact Jeannette Nelson by November 9, 2009, TTY (360) 902-9569 or (360) 902-9602.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The rule provides clarity concerning the priority of payments, how payments will be handled when a claimant is eligible for an unemployment claim but is paid extended or emergency benefits in error, and how the amount of extended benefits will be calculated when an individual's weekly benefit amount is temporarily increased.

Reasons Supporting Proposal: The proposed rules clarify the payment of extended unemployment benefits in coordination with the emergency unemployment compensation benefits paid under federal law.

Statutory Authority for Adoption: RCW 50.12.010, 50.12.040, 50.20.010.

Statute Being Implemented: RCW 50.22.010 and [50.22.]020.

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

Name of Proponent: Employment security department, governmental.

Name of Agency Personnel Responsible for Drafting: Juanita Myers, 212 Maple Park, Olympia, (360) 902-9665; Implementation and Enforcement: Nan Thomas, 212 Maple Park, Olympia, (360) 902-9303.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The proposed rules will not impose more than minor costs on businesses, nor will there be a disproportionate impact on small business. Any business costs associated with the rules are the result of the underlying legislation.

A cost-benefit analysis is not required under RCW 34.05.328. The proposed rules are not significant legislative rules as defined in RCW 34.05.328.

October 5, 2009
Paul Trause
Deputy Commissioner

NEW SECTION

WAC 192-240-060 What is the priority of payments? Any emergency unemployment compensation or any similar federal compensation may be paid before the state extended benefits authorized under Chapter 50.22 RCW at the discretion of the commissioner.

NEW SECTION

WAC 192-240-070 What happens if I am paid emergency or extended benefits when I am eligible for a new unemployment claim? If you are paid emergency unemployment compensation, state extended benefits, or any similar state or federal extension, and it is later discovered that you were eligible for a regular unemployment claim during all or part of the period in which you received such benefits, the regular unemployment claim takes priority. The balance on your new unemployment claim will be adjusted for any week(s) at issue, meaning those weeks in which you should have received regular unemployment benefits, subject to the following:

(1) Except as provided in subsection 4 of this section, you may not be paid twice for the same week

(2) If your new weekly benefit amount is equal to the amount you were paid for the weeks at issue, the amount you were paid in emergency unemployment compensation or extended benefits will be deducted from the maximum benefits payable on your new claim.

Example: Your previous weekly benefit amount was five hundred dollars. You received emergency unemployment compensation for eight weeks at this amount when it was discovered you were eligible for a new claim in the amount of five hundred dollars. The five hundred dollars paid for eight weeks will be deducted from the maximum benefits payable on your new claim.

(3) If your new weekly benefit amount is lower than the amount you were paid for the weeks at issue, the amount you were paid in emergency unemployment compensation or extended benefits that is equivalent to the weekly benefit amount on your new claim will be deducted from the maximum benefits payable on your new claim. The difference between the amounts paid in emergency unemployment compensation or extended benefits for the week(s) at issue and the weekly benefit amount on your new claim will be waived as provided in RCW 50.20.190.

Example: Your previous weekly benefit amount was five hundred dollars. You received emergency unemployment compensation for eight weeks at this amount when it was discovered you were eligible for a new claim in the amount of three hundred-fifty dollars. The three hundred-

fifty dollars for eight weeks will be deducted from the maximum benefits payable on your new claim. The one hundred-fifty dollar difference between your previous weekly benefit amount and your new weekly benefit amount will be waived.

(4) If your new weekly benefit amount is higher than the amount you were paid for the week(s) at issue, the amount you were paid in emergency unemployment compensation or extended benefits will be supplemented so that you receive your new weekly benefit amount for the weeks at issue and the total deducted from the maximum benefits payable on your new claim.

For example: Your previous weekly benefit amount was three hundred-fifty dollars. You received emergency unemployment compensation for eight weeks at this amount when it was discovered you were eligible for a new claim in the amount of five hundred dollars. You will be paid an additional one hundred-fifty dollars for each of the eight weeks at issue and the total deducted from the maximum benefits payable on your new claim.

NEW SECTION

WAC 192-240-080 How much will I receive in extended benefits if my regular weekly benefit amount is increased? (1)(a) If your weekly benefit amount for regular unemployment benefits is increased during your benefit year, the maximum amount of extended benefits payable will be the lesser of fifty percent of the total regular unemployment compensation paid to you for the benefit year or thirteen times the average weekly benefit amount paid during your benefit year.

Example: You receive regular unemployment benefits for twenty weeks at $200 and $245 for the remaining six weeks. The maximum benefits payable on your claim is $5,470. Your weekly benefit amount for extended benefits will be $245. The maximum extended benefits payable will be $2,735 which is the lesser of fifty percent of $5,470 or thirteen times $222.5 ($200 + $245 divided by 2, the average of both weekly benefit amounts, or $2,892).

(b) When the state is in a high unemployment period as defined in RCW 50.22.010(3), the maximum amount of extended benefits payable will be the lesser of eighty percent of the total regular unemployment compensation paid to you for the benefit year or twenty times the average weekly benefit amount paid during your benefit year.

(2) For purposes of this section, "average" means the average of the two weekly benefit amounts paid during your benefit year.

WSR 09-20-101
PROPOSED RULES
DEPARTMENT OF PERSONNEL

[Filed October 7, 2009, 9:50 a.m.]

Original Notice.

Exempt from preproposal statement of inquiry under RCW 34.05.310(4).

Title of Rule and Other Identifying Information: WAC 357-46-058 Is an employee who is rehired following layoff considered to have had a break in state service?, 357-46-059 Is a higher education employee who is rehired following layoff considered to have had a break in state service?, and 357-58-477 Is a WMS employee who is rehired following layoff considered to have had a break in state service?

Hearing Location(s): Department of Personnel, 600 South Franklin, Olympia, WA, on November 12, 2009, at 8:30 a.m.

Date of Intended Adoption: November 12, 2009.

Submit Written Comments to: Connie Goff, Department of Personnel, P.O. Box 47500, e-mail connieg@dop.wa.gov, fax (360) 586-4694, by November 5, 2009. FOR DOP TRACKING PURPOSES PLEASE NOTE ON SUBMITTED COMMENTS "FORMAL COMMENT."

Assistance for Persons with Disabilities: Contact department of personnel by November 5, 2009, TTY (360) 753-4107 or (360) 586-8260.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Currently WAC 357-46-058(2) states that an employee (general government and higher education) who is laid off is not considered to have had a break in service if within two years of separation the employee is appointed to a position from a layoff list, the general government transition pool or as a promotional candidate. Upon appointment the employee is reinstated with the seniority and unbroken service the employee had at the time of layoff. For general government employees the time spent off the payroll due to layoff is currently treated like leave without pay and the seniority and unbroken service dates must be adjusted.

We are proposing amending WAC 357-46-058 and 357-58-477 so that for general government employees the time spent off the payroll due to layoff will not be treated as leave without pay regardless of how the employee is appointed.

Although WAC 357-46-059 is a new rule which will address when a higher education employee is rehired following layoff, there is no change to how a higher education employee is treated when rehired following layoff.

Statutory Authority for Adoption: Chapter 41.06 RCW.

Statute Being Implemented: RCW 41.06.150.

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

Name of Agency Personnel Responsible for Drafting: Kristie Wilson, 521 Capitol Way South, (360) 664-6408; Implementation and Enforcement: Department of personnel.

No small business economic impact statement has been prepared under chapter 19.85 RCW.

A cost-benefit analysis is not required under RCW 34.05.328.

October 6, 2009
Eva N. Santos
Director

AMENDATORY SECTION (Amending WSR 09-11-063, filed 5/14/09, effective 6/16/09)

WAC 357-46-058 Is ((~~an~~)) a general government employee who is rehired following layoff considered to have had a break in state service? (1) ((~~An~~)) A general government employee laid off in accordance with the provisions

of WAC 357-46-010 or 357-58-445 is not considered to have had a break in continuous state service if within two years of separation the employee is appointed to a position((:

~~(a) From a layoff list or the general government transition pool; or~~

~~(b) As a promotional candidate in accordance with the employer's promotional policy~~)).

(2) Upon appointment, ((~~the~~)) a general government employee is reinstated with the ((~~seniority and unbroken service the employee had at the time of layoff. For a general government employee, the time spent off the payroll due to layoff is treated like leave without pay and seniority and unbroken service dates must be adjusted in accordance with WAC 357-31-345 and 357-46-055 respectively~~)) anniversary and unbroken service dates the employee had at the time of layoff. A full-time general government employee is given full-time credit towards seniority for the time spent off the payroll due to layoff. As provided in WAC 357-46-055(2) a part-time general government employee's seniority is calculated by determining the number of actual hours worked and/or in paid status, therefore a part-time employee shall not receive seniority credit for the time spent off the payroll due to layoff.

NEW SECTION

WAC 357-46-059 Is a higher education employee who is rehired following layoff considered to have had a break in state service? (1) A higher education employee laid off in accordance with the provisions of WAC 357-46-010 is not considered to have had a break in continuous state service if within two years of separation the employee is appointed to a position:

(a) From a layoff list or the general government transition pool; or

(b) As a promotional candidate in accordance with the employer's promotional policy.

(2) Upon appointment, the higher education employee is reinstated with the seniority and unbroken service the employee had at the time of layoff.

AMENDATORY SECTION (Amending WSR 09-11-063, filed 5/14/09, effective 6/16/09)

WAC 357-58-477 Is a WMS employee who is rehired following layoff considered to have had a break in state service? (1) An employee laid off in accordance with the provisions of WAC 357-58-445 is not considered to have had a break in continuous state service if within two years of separation the employee is appointed to a position((:

~~(a) From the general government transition pool; or~~

~~(b) As a promotional candidate in accordance with the employer's promotional policy~~)).

(2) Upon appointment, ((~~the~~)) an employee is reinstated with the ((~~seniority~~)) anniversary and unbroken service dates the employee had at the time of layoff. ((~~Time spent off the payroll due to layoff is treated like leave without pay and seniority and unbroken service dates must be adjusted in accordance with WAC 357-31-345 and 357-46-055 respectively~~)) A full-time employee is given full-time credit towards seniority for the time spent off the payroll due to layoff. As provided in WAC 357-46-055(2) a part-time employee's seniority is calculated by determining the number of actual hours worked and/or in paid status, therefore a part-time employee shall not receive seniority credit for the time spent off the payroll due to layoff.

WSR 09-20-102
PROPOSED RULES
DEPARTMENT OF PERSONNEL

[Filed October 7, 2009, 9:51 a.m.]

Original Notice.

Exempt from preproposal statement of inquiry under RCW 34.05.310(4).

Title of Rule and Other Identifying Information: WAC 357-19-070 What happens if an employee who is serving a probationary or trial service period accepts an appointment to another permanent position with the same employer?

Hearing Location(s): Department of Personnel, 600 South Franklin, Olympia, WA, on November 12, 2009, at 8:30 a.m.

Date of Intended Adoption: November 12, 2009.

Submit Written Comments to: Connie Goff, Department of Personnel, P.O. Box 47500, e-mail connieg@dop.wa.gov, fax (360) 586-4694, by November 5, 2009. FOR DOP TRACKING PURPOSES PLEASE NOTE ON SUBMITTED COMMENTS "FORMAL COMMENT."

Assistance for Persons with Disabilities: Contact department of personnel by November 5, 2009, TTY (360) 753-4107 or (360) 586-8260.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposed rule amendment will give employers discretion of whether or not to count time served in a current probationary or trial service period toward the probationary or trial service period of a new position.

Statutory Authority for Adoption: Chapter 41.06 RCW.

Statute Being Implemented: RCW 41.06.150.

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

Name of Agency Personnel Responsible for Drafting: Kristie Wilson, 521 Capitol Way South, (360) 664-6408; Implementation and Enforcement: Department of personnel.

No small business economic impact statement has been prepared under chapter 19.85 RCW.

A cost-benefit analysis is not required under RCW 34.05.328.

October 6, 2009
Eva N. Santos
Director

AMENDATORY SECTION (Amending WSR 05-01-206, filed 12/21/04, effective 7/1/05)

WAC 357-19-070 What happens if an employee who is serving a probationary or trial service period accepts an appointment to another permanent position with the same employer? If an employee accepts an appointment to

another permanent position with the same employer while serving a probationary or trial service period, the following applies:

(1) ((~~Time served in the initial probationary or trial service period counts towards the probationary or trial service period of the new position~~)) If the employer determines the positions or classes to which the positions are allocated are closely related the employer may count time served in the initial probationary or trial service towards the probationary or trial service period of the new position; or

(2) ((~~The probationary or trial service period starts over~~)) If the employer determines the positions or classes to which the positions are allocated are not closely related the probationary or trial service period of the new position starts over.

WSR 09-20-103

PROPOSED RULES

DEPARTMENT OF PERSONNEL

[Filed October 7, 2009, 9:55 a.m.]

Original Notice.

Exempt from preproposal statement of inquiry under RCW 34.05.310(4).

Title of Rule and Other Identifying Information: WAC 357-19-455 What is reemployment?

Hearing Location(s): Department of Personnel, 600 South Franklin, Olympia, WA, on November 12, 2009, at 8:30 a.m.

Date of Intended Adoption: November 12, 2009.

Submit Written Comments to: Connie Goff, Department of Personnel, P.O. Box 47500, e-mail connieg@dop.wa.gov, fax (360) 586-4694, by November 5, 2009. FOR DOP TRACKING PURPOSES PLEASE NOTE ON SUBMITTED COMMENTS "FORMAL COMMENT."

Assistance for Persons with Disabilities: Contact department of personnel by November 5, 2009, TTY (360) 753-4107 or (360) 586-8260.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposed rule amendment corrects the reemployment definition to match the definition found in WAC 357-01-280.

Statutory Authority for Adoption: Chapter 41.06 RCW.

Statute Being Implemented: RCW 41.06.150.

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

Name of Agency Personnel Responsible for Drafting: Kristie Wilson, 521 Capitol Way South, (360) 664-6408; Implementation and Enforcement: Department of personnel.

No small business economic impact statement has been prepared under chapter 19.85 RCW.

A cost-benefit analysis is not required under RCW 34.05.328.

October 6, 2009

Eva N. Santos

Director

AMENDATORY SECTION (Amending WSR 05-01-206, filed 12/21/04, effective 7/1/05)

WAC 357-19-455 What is reemployment? Reemployment is the appointment of a former permanent employee who had permanent status in a class with the same or similar job duties.

WSR 09-20-104

PROPOSED RULES

DEPARTMENT OF PERSONNEL

[Filed October 7, 2009, 9:57 a.m.]

Original Notice.

Exempt from preproposal statement of inquiry under RCW 34.05.310(4).

Title of Rule and Other Identifying Information: WAC 357-01-275 Reassignment and 357-19-165 What is the difference between reassignment and transfer?

Hearing Location(s): Department of Personnel, 600 South Franklin, Olympia, WA, on November 12, 2009, at 8:30 a.m.

Date of Intended Adoption: November 12, 2009.

Submit Written Comments to: Connie Goff, Department of Personnel, P.O. Box 47500, e-mail connieg@dop.wa.gov, fax (360) 586-4694, by November 5, 2009. FOR DOP TRACKING PURPOSES PLEASE NOTE ON SUBMITTED COMMENTS "FORMAL COMMENT."

Assistance for Persons with Disabilities: Contact department of personnel by November 5, 2009, TTY (360) 753-4107 or (360) 586-8260.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The definition of "reassignment" found in WAC 357-01-275 and 357-19-165 does not coincide with WAC 357-19-170. WAC 357-19-170 is the rule which grants the authority for an employer to reassign an employee. WAC 357-19-170 says an appointing authority may reassign an employee to a different position *within the same class* (no mention of a different class with the same salary range maximum). The proposed rule amendments to WAC 357-01-275 and 357-19-165 will correct this.

Statutory Authority for Adoption: Chapter 41.06 RCW.

Statute Being Implemented: RCW 41.06.150.

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

Name of Agency Personnel Responsible for Drafting: Kristie Wilson, 521 Capitol Way South, (360) 664-6408; Implementation and Enforcement: Department of personnel.

No small business economic impact statement has been prepared under chapter 19.85 RCW.

A cost-benefit analysis is not required under RCW 34.05.328.

October 6, 2009

Eva N. Santos

Director

AMENDATORY SECTION (Amending WSR 05-01-204, filed 12/21/04, effective 7/1/05)

WAC 357-01-275 Reassignment. An employer-initiated move of an employee within the employer from one position to another position in the same class ((~~or a different class with the same salary range maximum~~)).

AMENDATORY SECTION (Amending WSR 05-01-206, filed 12/21/04, effective 7/1/05)

WAC 357-19-165 What is the difference between reassignment and transfer? A reassignment is an employer-initiated move of an employee from one position to a comparable position in the same class ((~~or a different class with the same salary range maximum~~)). A transfer is an employee-initiated move from one position within or between employers in the same class or a different class with the same salary range maximum.

WSR 09-20-105
PROPOSED RULES
DEPARTMENT OF PERSONNEL

[Filed October 7, 2009, 9:58 a.m.]

Original Notice.

Exempt from preproposal statement of inquiry under RCW 34.05.310(4).

Title of Rule and Other Identifying Information: WAC 357-31-215 When may vacation leave be accumulated above the maximum two hundred forty hours?

Hearing Location(s): Department of Personnel, 600 South Franklin, Olympia, WA, on November 12, 2009, at 8:30 a.m.

Date of Intended Adoption: November 12, 2009.

Submit Written Comments to: Connie Goff, Department of Personnel, P.O. Box 47500, e-mail connieg@dop.wa.gov, fax (360) 586-4694, by November 5, 2009. FOR DOP TRACKING PURPOSES PLEASE NOTE ON SUBMITTED COMMENTS "FORMAL COMMENT."

Assistance for Persons with Disabilities: Contact department of personnel by November 5, 2009, TTY (360) 753-4107 or (360) 586-8260.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: It has been brought to our attention that the proposed deleted language is being interpreted to mean employees must use excess vacation accrual (EVA) before using justified excess vacation (JEV). EVA is the unprotected vacation leave above two hundred forty hours that is earned between anniversary dates. JEV is the vacation leave that is protected by a statement of necessity. Deletion of this language will help clarify that EVA does not have to be used first.

Statutory Authority for Adoption: Chapter 41.06 RCW.

Statute Being Implemented: RCW 41.06.150.

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

Name of Agency Personnel Responsible for Drafting: Kristie Wilson, 521 Capitol Way South, (360) 664-6408; Implementation and Enforcement: Department of personnel.

No small business economic impact statement has been prepared under chapter 19.85 RCW.

A cost-benefit analysis is not required under RCW 34.05.328.

October 6, 2009
Eva N. Santos
Director

AMENDATORY SECTION (Amending WSR 09-11-065, filed 5/14/09, effective 6/16/09)

WAC 357-31-215 When may vacation leave be accumulated above the maximum ((~~240~~)) two hundred forty hours? There are two circumstances in which vacation leave may be accumulated above the maximum of ((~~30~~)) thirty working days (((~~240~~)) two hundred forty hours).

(1) If an employee's request for vacation leave is denied by the employer, and the employee is close to the maximum vacation leave (((~~240~~)) two hundred forty hours), the employer must grant an extension for each month that the employer defers the employee's request for vacation leave. The employer must maintain a statement of necessity justifying the extension.

(2) As an alternative to subsection (1) of this section, employees may also accumulate vacation leave in excess of ((~~240~~)) two hundred forty hours as follows:

(a) An employee may accumulate the vacation leave days between the time ((~~30~~)) thirty days is accrued and his/her next anniversary date of state employment.

(b) Leave accumulated above ((~~240~~)) two hundred forty hours must be used by the next anniversary date and in accordance with the employer's leave policy. If such leave is not used before the employee's anniversary date, the excess leave is automatically lost and considered to have never existed.

(c) A statement of necessity, as described in subsection (1) ((~~above~~)) of this section, can only defer leave that the employee has not accrued as of the date of the statement of necessity. Any accrued leave in excess of ((~~240~~)) two hundred forty hours as of the date of the statement of necessity cannot be deferred regardless of circumstances. For example:

On June 15th, an employee is assigned to work on a special project. It is expected that the assignment will last six months. Due to an ambitious timeline and strict deadlines, the employee will not be able to take any vacation leave during that time.

((~~•~~)) On June 15th, the employee's vacation leave balance is ((~~260~~)) two hundred sixty hours.

((~~•~~)) The employee accrues ((~~10~~)) ten hours monthly.

((~~•~~)) The employee's anniversary date is October 16th.

Because the employee will not be able to use leave from June 15th through December 15th the employee files a statement of necessity asking to defer the leave accrued during this time. This deferred leave will not be lost as long as the employee uses the deferred hours by their next anniversary date (October 16th of the following year).

The ((~~20~~)) twenty hours of excess vacation leave the employee had on June 15th are not covered by the statement

of necessity. ((~~These hours will not be deferred and will be lost unless they are used before October 16th of the current year.~~))

WSR 09-20-107
PROPOSED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)
[Filed October 7, 2009, 10:17 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 09-01-143.

Title of Rule and Other Identifying Information: The department is repealing WAC 388-533-1000 First steps child care program.

Hearing Location(s): Blake Office Park East, Rose Room, 4500 10th Avenue S.E., Lacey, WA 98503 (one block north of the intersection of Pacific Avenue S.E. and Alhadeff Lane. A map or directions are available at http://www.dshs.wa.gov/msa/rpau/docket.html or by calling (360) 664-6094), on November 10, 2009, at 10:00 a.m.

Date of Intended Adoption: Not sooner than November 11, 2009.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504-5850, delivery 4500 10th Avenue S.E., Lacey, WA 98503, e-mail DSHSRPAURulesCoordinator@dshs.wa.gov, fax (360) 664-6185, by 5 p.m. on November 10, 2009.

Assistance for Persons with Disabilities: Contact Jennisha Johnson, DSHS rules consultant, by October 27, 2009, TTY (360) 664-6178 or (360) 664-6094 or by e-mail at johnsjl4@dshs.wa.gov.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The First Steps child care program is eliminated to meet the legislative requirements of sections 201 and 209 of the operating budget for fiscal years 2010 and 2011.

Reasons Supporting Proposal: The repeal of this rule is necessary for the department to fully meet the legislatively mandated appropriation reduction in chapter 564, Laws of 2009 (ESHB 1244), for maternity support services (WAC 388-533-1000 was repealed by emergency adoption effective June 1, 2009).

Statutory Authority for Adoption: Chapter 564, Laws of 2009 (ESHB 1244); RCW 74.08.090 and 74.09.800.

Statute Being Implemented: Chapter 564, Laws of 2009 (ESHB 1244).

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: Kathy Sayre, P.O. Box 45504, Olympia, WA 98504, (360) 725-1342; Implementation and Enforcement: Todd Sletvett, P.O. Box 45530, Olympia, WA 98504, (360) 725-1626.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The department analyzed the proposed rule repeal and concludes that it will impose no new costs on small businesses. The preparation of a comprehensive small business economic impact statement is not required.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Todd Sletvett, Section Manager, P.O. Box 45530, Olympia, WA 98504-5530, phone (360) 725-1626, fax (360) 664-4371, e-mail todd.slettvet@dshs.wa.gov [todd.sletvett@dshs.wa.gov].

October 5, 2009
Stephanie E. Vaughn
Rules Coordinator

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 388-533-1000	First steps child care program.

WSR 09-20-111
PROPOSED RULES
PROFESSIONAL EDUCATOR STANDARDS BOARD
[Filed October 7, 2009, 11:50 a.m.]

Continuance of WSR 09-16-054.

Preproposal statement of inquiry was filed as WSR 08-11-074.

Title of Rule and Other Identifying Information: New section WAC 181-78A-125 describes field placement agreements. WAC 181-78A-132 is a new section describing requirements for out-of-state institutions of higher education wishing to develop field placements within Washington state.

Hearing Location(s): Heathman Lodge, 7801 N.E. Green Drive, Vancouver, WA 98662, on November 12, 2009, at 8:30 a.m.

Date of Intended Adoption: November 12, 2009.

Submit Written Comments to: David Brenna, Legislative and Policy Coordinator, P.O. Box 47236, Olympia, WA 98504, e-mail david.brenna@k12.wa.us, fax (360) 586-4548, by November 5, 2009.

Assistance for Persons with Disabilities: Contact David Brenna, by November 5, 2009, TTY (360) 664-3631 or (360) 725-6238.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: New section WAC 181-78A-125 provides rules for educator preparation programs to establish and maintain field placement agreements with all Washington school districts. Agreements to include duties, qualifications, length of placement and authorizing signatures.

New section WAC 181-78A-132 provides rules for out-of-state institution developing filed placements. Require-

ments include documentation of the institutions regional status, state approval and, for programs offering degrees, higher education coordinating board approval. Rules further require program description in applications, start date and enrollment projections. Rule includes data and demonstration of regional demand as well as Washington state schold [school] district support. The field experience program must be based on Washington state standards for educator preparation. Out-of-state programs must prepare and submit agreements per WAC 181-78A-125, report to the professional educator standards board (PESB) as required and the PESB is required to post information on field experience programs in Washington state developed under this section on their web site.

Reasons Supporting Proposal: Demonstrated skill and knowledge do not include ethical practice; issue of teacher conduct is addressed in WAC 181-87-005.

Statutory Authority for Adoption: RCW 28A.410.210.

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

Name of Proponent: Professional educator standards board, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation and Enforcement: David Brenna, P.O. Box 42736, Olympia, WA 98504, (360) 725-6238.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The proposed amendment does not have an impact on small business and therefore does not meet the requirements for a statement under RCW 19.85.030 (1) or (2).

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting David Brenna, P.O. Box 47236, Olympia, WA 98504, phone (360) 725-6238, fax (360) 586-3631, e-mail david.brenna@k12.wa.us.

July 29, 2009
David Brenna
Legislative and
Policy Coordinator

NEW SECTION

WAC 181-78A-125 Field placement agreements. All educator preparation programs approved by the professional educator standards board shall establish and maintain field placement agreements with all Washington school districts in which candidates are placed for field experiences leading to certification or endorsement.

Each field placement agreement shall include, but not be limited to:

(1) Assurances that:

(a) Fingerprint and character clearance under RCW 28A.410.010 must be current at all times during the field experience; and

(b) Candidates will not be placed in settings that present conflict of interest or where personal relationships exist that could interfere with objective evaluation of candidates.

(2) Qualifications of the proposed site supervisor for each site and qualifications of each school's cooperating teacher/administrator;

(3) Clear description by institution of duties and responsibilities of site supervisor and cooperating teacher/administrator;

(4) Anticipated length and nature of field experience;

(5) Signatures from district representative.

NEW SECTION

WAC 181-78A-132 Programs approved in other states operating field experiences in Washington state. State approved preparation programs at a regionally accredited college or university in the professional field for which certification is issued that wish to enroll candidates for certification or endorsement in a supervised field experience under WAC 181-78A-125 within Washington state shall comply with the following:

(1) Application for approval. Each institution must submit a proposal that addresses components adopted and published by the professional educator standards board, including:

(a) Verification of regional accreditation;

(b) Verification of state approval;

(c) Verification of higher education coordinating board approval (if offering degree program);

(d) Planned certification or endorsement program;

(e) Proposed start date;

(f) Projected enrollment;

(g) Data indicating need for program related to geographic location or nature of program offered;

(h) Explanation of means by which program will ensure candidates have formalized learning opportunities rooted in Washington state standards.

(2) Field placement agreements. Institutions must comply with requirements of WAC 181-78A-125.

(3) Institutions will comply with applicable annual reporting requirements requested by the professional educator standards board. Failure to report any change in status as submitted under subsection (1)(a) through (h) of this section may result in a loss of approval to operate field placements in Washington state.

(4) The professional educator standards board shall publish on its web site a list of those out-of-state programs approved to offer field experiences within Washington state.

(5) The professional educator standards board shall publish on its web site relevant program approval status information on the out-of-state program from the state in which the program is approved.

(6) Out-of-state institutions with candidates needing to arrange a supervised field experience within Washington state and through an in-state institution on an infrequent basis for a limited number of candidates may seek a waiver for the requirements of this section from the professional educator standards board.