WSR 19-23-007
PERMANENT RULES
DEPARTMENT OF HEALTH
(Veterinary Board of Governors)

[Filed November 6, 2019, 3:18 p.m., effective December 7, 2019]

Effective Date of Rule: Thirty-one days after filing.

Purpose: WAC 246-933-250, veterinarian examination and licensure requirements. The veterinary board of governors (board) is removing the clinical competency test (CCT) as a licensure requirement. Under WAC 246-933-250, licensees were required to "successfully complete either the North American Veterinary Licensing Examination (NAVLE), or the National Board Examination for Veterinary Medical Licensing (NBE) with the CCT." The CCT was created in 1979 and was required with the NBE at that time. Starting in 2000, the NAVLE took the place of both the NBE and CCT. Without the adopted rule amendment applicants who took the licensure exam prior to 1979 (when the CCT did not exist), would not be able to get licensure through WAC 246-933-250. The board finds that applicants who were initially licensed without taking the CCT have years of proven competency by virtue of their careers in veterinary medicine. The board adopted this amendment to eliminate a barrier to licensure.

Citation of Rules Affected by this Order: Amending WAC 246-933-250.

Statutory Authority for Adoption: RCW 18.92.030.

Adopted under notice filed as WSR 19-15-077 on July 17, 2019.

A final cost-benefit analysis is available by contacting Loralei Walker, P.O. Box 47852, Olympia, WA 98504-7852, phone 360-236-4947, fax 360-236-4947 [360-236-2901], TTY 360-833-6388 or 711, email loralei.walker@doh.wa.gov.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 1, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 1, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 1, Repealed 0.

Date Adopted: September 23, 2019.

Elizabeth C. Davies, DVM, Chair
Veterinary Board of Governors

AMENDATORY SECTION (Amending WSR 07-20-036, filed 9/25/07, effective 10/26/07)

WAC 246-933-250 Examination and licensure requirements. To qualify for licensure in this state, a candidate must:

(1) Successfully complete either the North American Veterinary Licensing Examination (NAVLE)((~~,~~)) or the National Board Examination for Veterinary Medical Licensing (NBE)((~~, with the Clinical Competency Test (CCT)~~)); and

(2) Successfully complete the Washington state jurisprudence examination; and

(3) Be a graduate of a program that is accredited by the American Veterinary Medical Association. A person who is a graduate of a college of veterinary medicine not accredited by the American Veterinary Medical Association must:

(a) Successfully complete the American Veterinary Medical Association's Educational Commission for Foreign Veterinary Graduates program (ECFVG); or

(b) Successfully complete the American Association of Veterinary State Board's Program for the Assessment of Veterinary Education Equivalence (PAVE); and

(4) Complete four clock hours of AIDS education as required in chapter 246-12 WAC, Part 8.

WSR 19-23-008
PERMANENT RULES
HEALTH CARE AUTHORITY

[Filed November 6, 2019, 3:52 p.m., effective December 7, 2019]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The agency is revising this section to strike subsection (2)(a) to align with changes in 42 U.S.C. 1396a (a)(25)(E) which removed prenatal care from the list of medical services that the agency pays and then seeks reimbursements from a liable third party. State medicaid agencies must use standard coordination of benefits cost avoidance when processing prenatal services claims.

Citation of Rules Affected by this Order: Amending WAC 182-501-0200.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160; 42 U.S.C. 1396a (a)(25)(E).

Adopted under notice filed as WSR 19-20-116 on October 2, 2019.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 1, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making:

New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 1, Repealed 0.

Date Adopted: November 6, 2019.

Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 16-23-021, filed 11/4/16, effective 1/1/17)

WAC 182-501-0200 Third-party resources. (1) The medicaid agency requires a provider to seek timely reimbursement from a third party when a client has available third-party resources, except as described under subsections (2) and (3) of this section.

(2) The agency pays for medical services and seeks reimbursement from a liable third party when the claim is for any of the following:

(a) ((~~Prenatal care;~~

~~(b)~~)) Labor, delivery, and postpartum care (except inpatient hospital costs) for a pregnant woman; or

((~~(c)~~)) (b) Preventive pediatric services as covered under the early and periodic screening, diagnosis and treatment program.

(3) The agency pays for medical services and seeks reimbursement from any liable third party when both of the following apply:

(a) The provider submits to the agency documentation of billing the third party and the provider has not received payment after thirty days from the date of services; and

(b) The claim is for a covered service provided to a client on whose behalf the office of support enforcement is enforcing ((~~an absent~~)) a noncustodial parent to pay support. For the purpose of this section, "is enforcing" means the ((~~absent~~)) noncustodial parent either:

(i) Is not complying with an existing court order; or

(ii) Received payment directly from the third party and did not pay for the medical services.

(4) The provider may not bill the agency or the client for a covered service when a third party pays a provider the same amount as or more than the agency rate.

(5) When the provider receives payment from a third party after receiving reimbursement from the agency, the provider must refund to the agency the amount of the:

(a) Third-party payment when the payment is less than the agency's maximum allowable rate; or

(b) Agency payment when the third-party payment is equal to or more than the agency's maximum allowable rate.

(6) The agency does not pay for medical services if third-party benefits are available to pay for the client's medical services when the provider bills the agency, except under subsections (2) and (3) of this section.

(7) The client is liable for charges for covered medical services that would be paid by the third-party payment when the client either:

(a) Receives direct third-party reimbursement for the services; or

(b) Fails to execute legal signatures on insurance forms, billing documents, or other forms necessary to receive insurance payments for services rendered. See WAC 182-503-0540 for assignment of rights.

(8) The agency considers an adoptive family to be a third-party resource for the medical expenses of the birth mother and child only when there is a written contract between the adopting family and either the birth mother, the attorney, the provider, or the adoption service. The contract must specify that the adopting family will pay for the medical care associated with the pregnancy.

(9) A provider cannot refuse to furnish covered services to a client because of a third-party's potential liability for the services.

(10) For third-party liability on personal injury litigation claims, the agency or managed care organization (MCO) is responsible for providing medical services under WAC 182-501-0100.

WSR 19-23-010
PERMANENT RULES
DEPARTMENT OF REVENUE

[Filed November 7, 2019, 6:54 a.m., effective December 8, 2019]

Effective Date of Rule: Thirty-one days after filing.

Purpose: WAC 458-16-210 and 458-16-260 are being amended to clarify property tax exemption standards and requirements for certain nonprofit organizations. Providing the qualifying standards used by the department of revenue when evaluating nonprofit exemption applications will provide nonprofit organizations with a better understanding of the exemption requirements before they apply.

Citation of Rules Affected by this Order: Amending WAC 458-16-210 Nonprofit organizations or associations organized and conducted for nonsectarian purposes and 458-16-260 Nonprofit child day care centers, libraries, orphanages, homes for sick or infirm, hospitals, outpatient dialysis facilities.

Statutory Authority for Adoption: RCW 84.36.865.

Adopted under notice filed as WSR 19-18-035 on August 29, 2019.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 2, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 2, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 2, Repealed 0.

Date Adopted: November 7, 2019.

Atif Aziz
Rules Coordinator

AMENDATORY SECTION (Amending WSR 15-07-021, filed 3/10/15, effective 4/10/15)

WAC 458-16-210 Nonprofit organizations ((~~or~~)), associations, or corporations organized and conducted for nonsectarian purposes. (1) **Introduction.** This rule explains the real and personal property tax exemption available under ((~~the provisions of~~)) RCW 84.36.030(1) to nonprofit organizations ((~~or~~)), associations, or corporations organized and conducted for nonsectarian purposes.

(2) **Definitions.** For purposes of this rule, the following definitions apply:

(a) "Benevolent((~~" refers to~~)) social services" ((~~or programs directed at~~)) are services provided to persons of all ages ((~~arising from or prompted by motives of charity or a sense of benevolence, that are marked by a kindly disposition~~)) for charitable reasons to promote the happiness and prosperity of others ((~~by~~)) through generosity ((~~in~~)) and pleasure at doing good works, or ((~~are organized~~)) for the purpose of doing good. ((~~For example, a benevolent organization may provide~~)) Examples of benevolent social services include, but are not limited to, providing a food bank((~~, a~~)) or soup kitchen((~~, or counseling services at cost~~)).

(b) "Character building((~~" means~~)) social services" ((~~or programs designed~~)) are services offered for the general public good that assist people with general living ((~~skills, developing interview and~~)) or job seeking skills, or assist people in working towards independent living and self-sufficiency. ((~~These services include, but are not limited to, programs designed to develop an individual's moral or ethical strength, leadership, integrity, self-discipline, fortitude, self-esteem, and reputation.~~)) Examples of character building social services include, but are not limited to, providing financial assistance and counseling, and vocational training which includes resume writing and job interview training.

(c) "Commercial" refers to an activity or enterprise that has profit making as its primary purpose.

(d) "Community outreach group" means a nonprofit group organized to extend social services to a particular segment of the community. ((~~For example,~~)) Examples of a community outreach group include, but are not limited to, a rescue mission organized to feed the homeless or a program that targets juveniles "at risk" of criminal or abusive behavior.

(e) "Nonsectarian purpose" means a purpose that is not associated with or limited to a particular religious group or denomination.

(f) "Protective social services" ((~~refers to activities that are meant to cover, to guard, or to shield~~)) are services that protect other persons from injury or destruction ((~~or to~~)), save others from financial loss((~~. For example, a protective organization may provide housing~~)), or assist persons with behavioral problems by providing encouragement, support, and training. Examples of protective social services include, but are not limited to, providing housing, counseling, encouragement, or support for battered persons or ((~~for the developmentally disabled or may assist persons with behavioral problems by providing encouragement, support, and training~~)) the physically or mentally disabled.

(g) "Rehabilitative ((~~or rehabilitation" refers to activities designed to~~)) social services" are services that restore individuals to a former capacity, to a condition of health, or to useful or constructive activity. ((~~For example, a~~)) Examples of rehabilitative ((~~organization may assist~~)) social services include, but are not limited to, assisting an exoffender's reentry into the community, assisting persons to overcome alcohol or substance abuse, or to overcome the effects of a physical injury, stroke, or heart attack.

((~~(h) "Social service" means programs designed to help people resolve problems, become more self-sufficient, prevent dependency, strengthen family relationships, and/or enhance the functioning of individuals in society. These services include, but are not limited to, programs in the general categories of:~~

~~(i) Socialization and development; and~~

~~(ii) Therapy, help, rehabilitation, and social protection.~~))

(3) **Exemption.** The real and personal property owned by nonprofit organizations, associations, or corporations (collectively, "organizations") are exempt from taxation if the ((~~organization, association, or corporation~~)) following requirements are satisfied:

(a) The nonprofit organization is organized and conducted for ((~~nonprofit and~~)) nonsectarian purposes((~~. To be exempt,~~));

(b) The property ((~~must be~~)) is exclusively used ((~~for~~)) to provide benevolent, character-building, ((~~benevolent,~~)) protective, or rehabilitative social services ((~~directed at~~)) to persons of all ages((~~.~~

~~(a)~~));

(c) The services provided by the nonprofit organization relieves a public obligation; and

(d) A portion of the nonprofit organization's services are gifted or donated to the people it serves as explained in subsection (4) of this section.

(4) **Gift and giving.** To qualify for this exemption, there must be an element of gift and giving ((~~in~~)) by the nonprofit ((~~organization's, association's, or corporation's activities, in relation~~)) to the people it serves. This ((~~element of gift and giving~~)) requires voluntarily giving something of value with no expectation of compensation or remuneration. ((~~The words "gift" and "giving," within the context of this rule, mean a voluntary act. In order to meet this requirement of gift and giving~~)) To comply with this requirement, the nonprofit organization((~~, association, or corporation must annually~~)) must demonstrate on an annual basis that it meets one of the following conditions:

((~~(i)~~)) (a) Provides goods and/or services free of charge or at a rate that is reduced by at least twenty percent ((~~below the total actual cost of such goods and/or services~~)) of its standard rate, to a minimum of fifteen percent of the total number of people ((~~assisted by that nonprofit organization, association, or corporation~~)) it assists; or

((~~(ii)~~)) (b) Contributes at least ten percent of its total annual income earned from the property towards the support of benevolent, character-building, ((~~benevolent,~~)) protective, or rehabilitative social service((~~s or~~)) programs. To determine whether the ten percent requirement has been met:

(i) "Total annual income" refers to the total income ((~~reported~~)) the nonprofit organization earns from the property and reports to the Internal Revenue Service for ((~~that~~)) the calendar year and includes, but is not limited to, funds received through direct and indirect public support, govern-

ment grants, membership fees, and other contributions. The term does not include funds that are specifically donated or contributed for capital improvements.

((~~(A) In order to meet this ten percent requirement,~~)) (ii) A nonprofit organization((~~, association, or corporation may include, but is not limited to,~~)) may include in its ten percent calculation the value of time volunteers donate to carry out program services and functions, the loan of its facilities free of charge to community outreach groups, and gifts of scholarships and other fee subsidies.

((~~(B)~~)) (A) Volunteer time. If a nonprofit organization ((~~utilizes~~)) includes volunteer time ((~~to reach the ten percent requirement~~)) in its ten percent calculation, it must maintain records identifying the individuals who ((~~donate~~)) donated their services and the number of hours they ((~~donate~~)) donated. The value of donated time will be calculated by using the federal minimum wage standard.

((~~(C)~~)) (B) Free use of facility. If a nonprofit organization allows community outreach groups to use its ((~~facilities~~)) facility free of charge, it must maintain records identifying the community outreach groups that used the ((~~exempt property~~)) facility and the number of hours ((~~each group used the exempt property~~)) of use. The value of this use will be calculated by taking the number of hours, or any portion of an hour, the facility is used by these groups and multiplying it by the customary ((~~charge~~)) fee the nonprofit organization((~~, association, or corporation~~)) charges to rent its facility to any other group.

((~~(b) Conditions and restrictions.~~)) (5) **Additional exemption information.** A nonprofit organization((~~, association, or corporation~~)) that applies for this property tax exemption must also comply with the provisions of WAC 458-16-165 and may not impose conditions or restrictions on the use of the exempt property ((~~by persons who do not personally pay the total actual cost of a social service~~)), except ((~~conditions or restrictions~~)) those that are reasonably necessary to safeguard the exempt property and to comply with ((~~the purposes of~~)) this exemption.

((~~(c)~~)) (a) Fraternal organizations. Property used by a fraternal organization or association for fraternal purposes does not qualify for ((~~an~~)) this exemption ((~~under this rule.~~

~~(d) Nonqualifying property~~)). For information regarding exemptions for property used for fraternal organizational purposes, see WAC 458-16-300 Public meeting hall—Public meeting place—Community meeting hall.

(b) Commercial purpose. If any portion of the nonprofit organization's ((~~or association's~~)) property is used for a commercial rather than a nonprofit, nonsectarian exempt purpose, then that portion will not qualify for this exemption and must be segregated from property used for exempt purposes. The burden is on the nonprofit organization to prove that the property is not used for a commercial purpose.

((~~(e)~~)) (c) Selling donated merchandise. When property is otherwise exempt under this rule, the sale of donated merchandise is ((~~considered~~)) not considered a disqualifying commercial purpose, but rather an exempt use of the property if the proceeds are dedicated to the exempt purpose ((~~associated with~~)) of the nonprofit((~~, nonsectarian~~)) organization ((~~or association~~)). For example, a job training program conducted through the operation of a thrift store ((~~operations that are restricted to the sale of "donated merchandise" will not jeopardize~~)) is eligible for this exemption if the ((~~claimant~~)) thrift store can verify the proceeds are directed to an exempt purpose.

((~~(f)~~)) (d) Property with option to repurchase. According to RCW 84.36.031, property leased, loaned, ((~~or~~)) sold with the option to repurchase, or otherwise made available to organizations described in RCW 84.36.030, does not qualify for ((~~this~~)) an exemption under RCW 84.36.030 unless:

(i) The property is owned by an organization exempt under RCW 84.36.020 or 84.36.030 and the organization loans, leases, or rents the property to another organization for the exempt purposes ((~~described~~)) provided in RCW 84.36.-030; or

(ii) The property is owned by an entity formed exclusively for the purpose of leasing the property to an organization that will use the property for the exempt purposes ((~~described~~)) provided in RCW 84.36.030 if:

(A) The lessee uses the property for the exempt purposes provided in RCW 84.36.030;

(B) The immediate previous owner of the property had received an exemption under RCW 84.36.020 or 84.36.030 for the property; and

(C) The benefit of the exemption ((~~inures to the benefit of the lessee organization.~~

~~(4) **Additional requirements.** Any organization or association that applies for a property tax exemption under this rule must also comply with the provisions of WAC 458-16-165. WAC 458-16-165 provides additional conditions and requirements that must be complied with to obtain a property tax exemption pursuant to RCW 84.36.030~~)) is passed on to the nonprofit organization using the property for exempt purposes.

AMENDATORY SECTION (Amending WSR 15-07-021, filed 3/10/15, effective 4/10/15)

WAC 458-16-260 Nonprofit child day care centers, free libraries, orphanages, homes for sick or infirm, hospitals, outpatient dialysis facilities. (1) **Introduction.** This rule explains the real and personal property tax exemption available under ((~~the provisions of~~)) RCW 84.36.040 for property used by nonprofit child day care centers, free libraries, orphanages, homes for the sick or infirm, hospitals, and outpatient dialysis facilities. In addition, this rule ((~~also~~)) explains the real and personal property tax exemption available to property leased to and used by a hospital for hospital purposes ((~~if the~~)) for a hospital that is established under chapter 36.62 RCW, or is owned and operated by a public hospital district established under chapter 70.44 RCW.

(2) **Definitions.** For purposes of this rule, the following definitions apply:

(a) "Child day care center" means a nonprofit organization that regularly provides child day care and early learning services for a group of children for periods of less than twenty-four consecutive hours.

(b) "Convalescent" or "chronic care" means any or all procedures commonly ((~~employed~~)) provided in caring for the sick including, but not limited to, administering medicines, preparing special diets, providing bedside nursing care,

applying dressings and bandages, and carrying out any treatment prescribed by a duly licensed practitioner of the healing arts.

((~~(b) "Child day care center" means a nonprofit organization that regularly provides child day care and early learning services for a group of children for periods of less than twenty-four consecutive hours.~~))

(c) "Free library" means a building or room containing collections of books, periodicals, other written materials such as magazines and newspapers, and audio or visual recordings. A free library must be accessible to the public for viewing, listening to, or borrowing these materials without charge. A nominal fee may be imposed for any materials that are damaged, lost, or not returned by the borrower in a timely manner. In the context of this rule, a "free library" does not include a library owned by an entity listed in RCW 84.36.010(1).

(d) "Home for the sick or infirm" means any home, place, or institution that operates or maintains facilities to provide convalescent or chronic care, or both, for three or more persons not related by blood or marriage to the operator, who by reason of illness or infirmity, are unable to properly care for themselves.

(i) The services must be provided to persons over a continuous period of twenty-four hours or more.

(ii) A boarding home, guest home, hotel, or similar institution that is ((~~held forth~~)) offered to the public as providing and supplying only room, board, or laundry services to persons who do not need medical or nursing treatment or supervision is not considered a "home for the sick or infirm" for purposes of this rule.

((~~(d)~~)) (e) "Hospital" means a nonprofit organization, association, or corporation engaged in providing medical, surgical, nursing, or related health care services for the prevention, diagnosis, or treatment of human illness, pain, injury, disability, deformity, or abnormality, including mental illness, treatment of mentally incompetent persons, or treatment of chemically dependent persons. The term also ((~~means all~~)) includes:

(i) Buildings or portions of buildings that are currently licensed as part of a hospital pursuant to chapters 70.41 or 71.12 RCW, and are part of an integrated, interrelated, homogeneous unit exclusively used for hospital purposes. The licensed hospital must be able to provide health care services to inpatients over a continuous period of twenty-four hours or more((~~. The term also includes:~~

~~(i)~~));

(ii) Administrative and support facilities integral and necessary to the functioning of the licensed hospital;

((~~(ii)~~)) (iii) Buildings used as a residence for persons engaged or employed on a regular basis in the operation of a licensed hospital. Such buildings include, but are not limited to, a nurse's home or a residence for hospital employees; and

((~~(iii)~~)) (iv) Residential units administered by a licensed hospital that are exclusively used to temporarily house families of inpatients in an integrated program of therapy.

"Hospital" does not ((~~mean~~)) include:

(A) Hotels or similar places that furnish only food and lodging or simple domiciliary care;

(B) Clinics or physician's offices ((~~not~~)), unless licensed as part of a hospital((~~, where patients are not regularly kept as bed patients for twenty-four hours or more~~));

(C) Nursing homes as defined in chapter 18.51 RCW; and

(D) Maternity homes as defined in chapter 18.46 RCW.

(3) **Exemption for exclusively used property.** A nonprofit organization, association, or corporation (collectively, "organization") that operates one of the following institutions is exempt from taxation on all real and personal property exclusively used ((~~by a nonprofit organization, association, or corporation for the following institutions is exempt from taxation~~)) for the actual operation of the activity for which the exemption is granted:

(a) Child day care centers;

(b) Free ((~~public~~)) libraries;

(c) Orphanages and orphan ((~~asylums~~)) shelters;

(d) Homes for the sick or infirm;

(e) Hospitals for the sick; and

(f) Outpatient dialysis facilities.

(4) **Exemption for loaned, leased, or rented property.** Property loaned, leased, or rented to an institution listed in subsection((~~s (3)(a) through (f)~~)) (3) of this rule is also exempt from taxation if:

(a) The property is exclusively used by the nonprofit organization((~~, association, or corporation;~~

~~(b) The benefit of the exemption inures to the user~~)) for the actual operation of the activity for which the exemption is granted;

(b) The benefit of the exemption is passed on to the nonprofit organization using the property for exempt purposes; and

(c) The property was specifically identified as loaned, leased, or rented when the application for exemption was made.

(5) **Property leased or rented to and used by publicly owned and operated hospitals.** All real and personal property leased or rented to and used by a hospital for hospital purposes as defined in subsection (2)(e) of this rule is exempt from property tax if the hospital is established under chapter 36.62 RCW or is owned and operated by a public hospital district established under chapter 70.44 RCW. The benefit of the exemption must ((~~inure to the entity using the exempt property~~)) be passed on to the nonprofit organization using the property for exempt purposes.

(6) **Additional requirements.** Any nonprofit organization ((~~or association~~)) that applies for a property tax exemption under this rule must also comply with the provisions of WAC 458-16-165. ((~~WAC 458-16-165 provides additional conditions and requirements that must be complied with to obtain a property tax exemption under RCW 84.36.040.~~))

WSR 19-23-034

PERMANENT RULES

HORSE RACING COMMISSION

[Filed November 12, 2019, 7:39 a.m., effective December 13, 2019]

Effective Date of Rule: Thirty-one days after filing.

Purpose: To increase license fees to cover the cost of the program as required in RCW 67.16.020.

Citation of Rules Affected by this Order: Amending WAC 260-36-085.

Statutory Authority for Adoption: RCW 67.16.020.

Adopted under notice filed as WSR 19-19-006 on September 6, 2019.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 1, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 1, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 1, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: November 8, 2019.

Douglas L. Moore
Executive Secretary

AMENDATORY SECTION (Amending WSR 12-23-015, filed 11/9/12, effective 12/10/12)

WAC 260-36-085 License and fingerprint fees. (1) The following are the license fees for any person actively participating in racing activities:

Apprentice jockey	$((~~83.00~~)) 96.00
Assistant trainer	$((~~40.00~~)) 46.00
Association employee - Management	$((~~27.00~~)) 31.00
Association employee - Hourly/seasonal	$((~~17.00~~)) 20.00
Association volunteer nonpaid	No fee
Authorized agent	$((~~27.00~~)) 31.00
Clocker	$((~~27.00~~)) 31.00
Exercise rider - Farm	$((~~83.00~~)) 96.00
Exercise rider - Track	$((~~83.00~~)) 96.00
Groom	$((~~27.00~~)) 31.00
Honorary licensee	$((~~17.00~~)) 20.00
Jockey agent	$((~~83.00~~)) 96.00
Jockey	$((~~83.00~~)) 96.00
Other	$((~~27.00~~)) 31.00
Owner	$((~~83.00~~)) 96.00
Pony rider - Farm	$((~~83.00~~)) 96.00
Pony rider - Track	$((~~83.00~~)) 96.00
Service employee	$((~~27.00~~)) 31.00
Spouse groom	$((~~27.00~~)) 31.00
Stable license	$((~~51.00~~)) 59.00
Trainer	$((~~83.00~~)) 96.00
Vendor	$((~~127.00~~)) 146.00
Veterinarian	$((~~127.00~~)) 146.00

(2) Exercise and pony riders.

(a) A person receiving an exercise rider - track license must first obtain an exercise rider - farm license if that person works off the grounds of a Washington race track. A person receiving a second exercise rider's license will not be charged an additional license fee for that second license.

(b) A person receiving a pony rider - track license must first obtain a pony rider - farm license if that person works off the grounds of a Washington race track. A person receiving a second pony rider's license will not be charged an additional license fee for that second license.

(3) In other cases, the license fee for multiple licenses may not exceed $((~~127.00~~)) 146.00, except persons applying for owner, veterinarian or vendor license must pay the license fee established for each of these licenses.

The following are examples of how this section applies:

Example one - A person applies for the following licenses: Trainer ($((~~83.00~~)) 96.00), exercise rider ($((~~83.00~~)) 96.00), and pony rider ($((~~83.00~~)) 96.00). The total license fee for these multiple licenses would only be $((~~127.00~~)) 146.00.

Example two - A person applies for the following licenses: Owner ($((~~83.00~~)) 96.00), trainer ($((~~83.00~~)) 96.00) and exercise rider ($((~~83.00~~)) 96.00). The total cost of the trainer and exercise rider license would be $((~~127.00~~)) 146.00. The cost of the owner license ($((~~83.00~~)) 96.00) would be added to the maximum cost of multiple licenses ($((~~127.00~~)) 146.00) for a total license fee of $((~~210.00~~)) 242.00.

Example three - A person applies for the following licenses: Owner ($((~~83.00~~)) 96.00), vendor ($((~~127.00~~)) 146.00), and exercise rider ($((~~83.00~~)) 96.00). The license fees for owner ($((~~83.00~~)) 96.00) and vendor ($((~~127.00~~)) 146.00) are both added to the license fee for exercise rider ($((~~83.00~~)) 96.00) for a total license fee of $((~~293.00~~)) 338.00.

In addition to the above fees, except for association volunteers (nonpaid) at Class C race meets and those excluded as listed in WAC 260-36-100, a $10.00 fee will be added to cover the costs of conducting a fingerprint-based background check. The background check fee will be assessed only once annually per person regardless of whether the person applies for more than one type of license in that year.

The commission will review license and fingerprint fees annually to determine if they need to be adjusted to comply with RCW 67.16.020.

WSR 19-23-035

PERMANENT RULES

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

(Developmental Disabilities Administration)

[Filed November 12, 2019, 9:35 a.m., effective December 13, 2019]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The department is amending WAC 388-827-0105 to clarify language and add a reference to the health care authority's regulations under WAC 182-512-0880.

Citation of Rules Affected by this Order: Amending WAC 388-827-0105.

Statutory Authority for Adoption: RCW 71A.12.030.

Adopted under notice filed as WSR 19-20-002 on September 18, 2019.

A final cost-benefit analysis is available by contacting Chantelle Diaz, P.O. Box 45310, Olympia, WA 98504-5310, phone 360-407-1589, fax 360-407-0955, TTY 1-800-833-6388, email Chantelle.Diaz@dshs.wa.gov.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 1, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 1, Repealed 0.

Date Adopted: November 12, 2019.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 18-06-101, filed 3/7/18, effective 4/7/18)

WAC 388-827-0105 Who is eligible for a state supplementary payment? (1) The developmental disabilities administration (DDA) must not enroll you in state supplementary payments after the effective date of this section, unless you are eligible for a state supplementary payment for prevocational legacy.

(2) To be eligible for a state supplementary payment, you must meet all general eligibility requirements under subsection (3) of this section and any applicable program-specific requirements under subsections (4) through (8) of this section.

(3) To be eligible for a state supplementary payment, you must:

(a) Be determined DDA eligible under chapter 388-823 WAC;

(b) Complete an in-person interview and reassessment with DDA once every twelve months—or more often if DDA deems it necessary—to determine whether you continue to meet eligibility requirements; and

(c) Be financially eligible because:

(i) You receive ((~~supplementary~~)) supplemental security income ((~~cash assistance~~)) (SSI) benefits for the month in which the state supplementary payment is issued; or

(ii) You receive social security Title II benefits as a disabled adult child ((~~and you would be eligible for SSI if you did not receive these benefits~~)) (DAC), your SSI was terminated due solely to your receipt of DAC benefits, and you are eligible for categorically needy medicaid due to the special income disregard described in WAC 182-512-0880(3).

(4) To be eligible for children's legacy care state supplementary payments, you must live with your family as defined in WAC 388-832-0001.

(5) To be eligible for a state supplementary payment for waiver services, you must be enrolled in a home and community-based services waiver program as described in chapter 388-845 WAC.

(6) To be eligible for prevocational legacy state supplementary payments, you must:

(a) Have left prevocational services on or after September 1, 2015; and

(b) Not be enrolled in a DDA residential habilitation service.

(7) To be eligible for residential habilitation state supplementary payments, you must be receiving a residential habilitation service as described in chapter 388-845 WAC and as identified in your person-centered service plan.

(8) To be eligible for state supplementary payments in lieu of individual and family services you must be:

(a) At least three years old; and

(b) Living with your family as defined in WAC 388-832-0001.

WSR 19-23-038
PERMANENT RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Economic Services Administration)

[Filed November 12, 2019, 10:12 a.m., effective December 13, 2019]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The department of social and health services, division of child support (DCS) is amending WAC 388-14A-3323 What happens in a hearing on a notice of support owed served under WAC 388-14A-3311?, to correct two typographical errors in two subsections of that rule. The amended rule makes the following changes: In subsection (4) the word "more" is replaced with "less"; and in subsection (5) the word "less" is replaced with "more."

DCS may serve a *notice of support owed* under RCW 26.23.110 when a support order provides that a parent is required to pay a portion of certain costs incurred on behalf of a child or children covered by the order but does not reduce the costs to a fixed dollar amount. The *notice of support owed* does not modify the underlying support order; it results in an administrative order which sets the amount owed by the parent as a sum certain, either as a lump sum reimbursement or as an ongoing sum certain amount to be paid each month, or both. DCS uses the *notice of support owed* process to determine sum certain amounts owed by the noncustodial parent (NCP) to the custodial parent (CP) for childcare or daycare (depending on the terminology of the underlying order), and also to determine sum certain amounts owed by either the NCP or the CP to the other for medical support.

Once the "original" administrative order requiring ongoing monthly payments is established pursuant to a *notice of support owed,* RCW 26.23.110 (12)(a) provides that DCS must provide for an "annual review" of that order at the request of one of the parties. Additionally, DCS may perform an annual review on its own initiative. The annual review includes a reconciliation based on the actual costs incurred over the time period since the administrative order was entered, to determine if (1) the amounts established by the administrative order were accurate, or (2) the actual costs were greater than, or less than, the amounts set in the order.

WAC 388-14A-3323 deals with administrative hearings on a *notice of support owed* for daycare/childcare expenses concerning either an original *notice of support owed* or an annual review of an administrative order based on a prior *notice of support owed*. For hearings regarding an annual review, the current rule has created issues due to an inadvertent reversal of the terms "less" and "more" in subsections (4) and (5) of the rule as described above. A literal (and admittedly, correct) reading of these subsections limits DCS' ability to provide a meaningful reconciliation if the parties have an administrative hearing in front of an administrative law judge (ALJ).

This amendment carries out the intent of the statute (RCW 26.23.110) and the rule by allowing an ALJ to give the appropriate relief in an administrative hearing based on an annual review when the ALJ determines that the parent who was obligated to pay either overpaid or underpaid, once the actual expenses incurred are known.

Citation of Rules Affected by this Order: Amending WAC 388-14A-3323.

Statutory Authority for Adoption: RCW 34.05.353(4), 26.09.015(20), 26.18.170(21), 26.23.050, 26.23.110(14), 43.20A.550, 74.04.055, 74.04.057, 74.08.090, 74.20A.310.

Adopted under notice filed as WSR 19-15-082 on July 18, 2019.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 1, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 1, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 1, Repealed 0.

Date Adopted: November 12, 2019.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 11-12-006, filed 5/19/11, effective 6/19/11)

WAC 388-14A-3323 What happens in a hearing on a notice of support owed served under WAC 388-14A-3311? (1) A hearing on a notice of support owed served under WAC 388-14A-3311 is subject to WAC 388-14A-3320 and this section.

(2) A hearing on a notice of support owed served under WAC 388-14A-3311 is only for the purpose of determining the amounts owed by the noncustodial parent (NCP) that are not stated as a fixed dollar amount in the underlying support order, either as part of the monthly support obligation or for nonmedical expenses of the children. See WAC 388-14A-3324 for the rules concerning a hearing on a notice of support owed for medical support.

(3) The administrative law judge (ALJ) must determine some or all of the following, depending on what was requested in the notice of support owed:

(a) The amount of monthly support as a fixed dollar amount;

(b) Any accrued arrears;

(c) Any difference between the NCP's obligation under a previous notice of support owed and his or her actual obligation after actual income or expenses are considered; and

(d) The amount of the NCP's share of nonmedical expenses for the children, including:

(i) The amount that the NCP must pay each month as his or her ongoing share of daycare and child care expenses for the children; and

(ii) Whether the custodial parent (CP) has provided sufficient proof of payment of daycare and child care expenses for the children; and

(iii) The amount of NCP's accrued debt for daycare and child care expenses.

(4) If the ALJ determines that the NCP's obligation under a previous notice of support owed is ((~~more~~)) less than his or her actual obligation under the order after actual expenses or income are considered, the ALJ may not set a payment schedule on the support debt.

(5) If the ALJ determines that the NCP's obligation under a previous notice of support owed is ((~~less~~)) more than his or her actual obligation under the order after actual expenses or income are considered, and the parties cannot agree on how the overpayment may be credited or repaid, the ALJ must enter an order providing that any difference may be:

(a) Applied as an offset to any nonassistance child support arrears owed by the NCP to the CP.

(b) In the form of a credit against the NCP's future child support obligation:

(i) Spread equally over a twelve-month period starting the month after the administrative order becomes final; or

(ii) When the future support obligation will end under the terms of the order in less than twelve months, spread equally over the life of the order.

(c) Paid in the form of a direct reimbursement by the CP to the NCP, but only with the consent of the CP, unless support has been assigned to the state.

WSR 19-23-039
PERMANENT RULES
DEPARTMENT OF HEALTH

[Filed November 12, 2019, 1:13 p.m., effective December 13, 2019]

Effective Date of Rule: Thirty-one days after filing.

Purpose: WAC 246-247-035 National standards adopted by reference for sources of radionuclide emissions, this rule making updates the federal regulations publication date from 2018 to the most recently adopted 2019 version previously adopted by reference. This amendment makes no changes to any requirements previously adopted, but is required for the department of health to receive delegation of the radionuclide air emissions program from the United States Environmental Protection Agency.

Citation of Rules Affected by this Order: Amending WAC 246-247-035.

Statutory Authority for Adoption: RCW 70.98.050 and 70.98.080(5).

Adopted under notice filed as WSR 19-20-028 on September 23, 2019.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 1, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 1, Repealed 0.

Date Adopted: November 12, 2019.

Lauren Jenks
Assistant Secretary

AMENDATORY SECTION (Amending WSR 19-04-042, filed 1/29/19, effective 3/1/19)

WAC 246-247-035 National standards adopted by reference for sources of radionuclide emissions. (1) In addition to other requirements of this chapter, the following federal standards, as in effect on July 1, ((~~2018~~)) 2019, are adopted by reference except as provided in subsection (2) of this section.

(a) For federal facilities:

(i) 40 C.F.R. Part 61, Subpart A - General Provisions.

(ii) 40 C.F.R. Part 61, Subpart H - National Emission Standards for Emissions of Radionuclides Other Than Radon From Department of Energy Facilities.

(iii) 40 C.F.R. Part 61, Subpart I - National Emission Standards for Radionuclide Emissions From Federal Facilities Other Than Nuclear Regulatory Commission Licensees and Not Covered by Subpart H.

(iv) 40 C.F.R. Part 61, Subpart Q - National Emission Standards for Radon Emissions From Department of Energy Facilities.

(b) For nonfederal facilities:

(i) 40 C.F.R. Part 61, Subpart A - General Provisions.

(ii) 40 C.F.R. Part 61, Subpart B - National Emission Standards for Radon Emissions From Underground Uranium Mines.

(iii) 40 C.F.R. Part 61, Subpart K - National Emission Standards for Radionuclide Emissions From Elemental Phosphorus Plants.

(iv) 40 C.F.R. Part 61, Subpart R - National Emissions Standards for Radon from Phosphogypsum Stacks.

(v) 40 C.F.R. Part 61, Subpart T - National Emission Standards for Radon Emissions From the Disposal of Uranium Mill Tailings.

(vi) 40 C.F.R. Part 61, Subpart W - National Emission Standards for Radon Emissions From Operating Mill Tailings.

(2) References to "Administrator" or "EPA" in 40 C.F.R. Part 61 include the department of health except in any section of 40 C.F.R. Part 61 for which a federal rule or delegation indicates that the authority will not be delegated to the state.

WSR 19-23-045
PERMANENT RULES
DEPARTMENT OF FINANCIAL INSTITUTIONS

[Filed November 13, 2019, 11:43 a.m., effective December 14, 2019]

Effective Date of Rule: Thirty-one days after filing.

Purpose: This rule provides procedures for Washington state-chartered credit unions to request powers and authorities allowed in other states when certain requirements are met.

Citation of Rules Affected by this Order: New WAC 208-400-040.

Statutory Authority for Adoption: RCW 31.12.516.

Adopted under notice filed as WSR 19-17-079 on August 20, 2019.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 1, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: November 13, 2019.

Amy B. Hunter, Director
Division of Credit Unions

NEW SECTION

WAC 208-400-040 Parity requests. Procedures for requesting powers and authorities authorized in other states.

(1) A credit union must send written notice to the director, by United States mail or by electronic delivery, of its intent to exercise a power or authority that it would have if it were an out-of-state credit union.

(2) The written request must provide the following information in order to be considered complete:

(a) A description of the specific proposed powers or authorities and how the power or authority will serve the convenience and advantage of the credit union's members;

(b) The state law citations upon which the powers or authorities are based;

(c) A description of the policies, procedures, or other documents the credit union will use in implementing the powers or authorities;

(d) A description of how the powers or authorities will impact the credit union's safety and soundness, including net worth and earnings; and

(e) Any actions planned to mitigate the safety and soundness risks created by the requested powers and authorities.

(3) The director shall grant a parity request if the director finds:

(a) The request is in accordance with the requirements of RCW 31.12.404;

(b) The power or authority is in the interests of the members of the credit union and maintains the fairness of competition and parity between state-chartered credit unions and out-of-state credit unions; and

(c) The power or authority can be implemented by the credit union in a safe and sound manner.

(4) The director may ask the credit union to waive or extend the thirty day response time set forth in RCW 31.12.-404(4).

(5) Absent a waiver or extension, if the director takes no action on the request within thirty days of delivery of the notice, the right to exercise the power is deemed granted.

(6) The director may attach restrictions or limitations on a credit union's new powers or authorities.

WSR 19-23-047
PERMANENT RULES
STUDENT ACHIEVEMENT COUNCIL

[Filed November 13, 2019, 12:26 p.m., effective December 14, 2019]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The definition of "eligible employer" is amended to clarify existing limitations on nonprofit organizations and private sector employers of students receiving financial assistance under the state work-study program (chapters 28B.12 RCW, 250-40 WAC). An existing prohibition of work that is "sectarian related" is amended to expand student employment placements to more eligible employers and clarify the types of work that remains prohibited.

*"Eligible employer" is defined to include any eligible institution of postsecondary education, any nonprofit organization, or any private sector employer. The current definition includes only public institutions and nonsectarian nonprofit organizations. WAC 250-40-030.

*The types of work prohibited are revised to exclude only work that directly involves religious worship, exercise or instruction, as well as continuing the prohibition of any partisan or nonpartisan political activity. WAC 250-40-050.

Citation of Rules Affected by this Order: Amending WAC 250-40-030 and 250-40-050.

Statutory Authority for Adoption: RCW 28B.12.060.

Other Authority: RCW 28B.76.120, 28B.77.050.

Adopted under notice filed as WSR 19-19-026 on September 10, 2019.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 2, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: November 12, 2019.

Michael P. Meotti
Executive Director

AMENDATORY SECTION (Amending WSR 02-20-083, filed 9/30/02, effective 10/31/02)

WAC 250-40-030 Definitions. (1) "Financial need" shall be the difference between the budgetary cost to the student attending an institution of postsecondary education and the total family contribution which the institutional financial aid administrator determines can reasonably be expected to be available to the student for meeting such costs.

(2) "Budgetary cost" of attending an institution shall consist of those costs required to support the individual and other costs in accordance with federal costs of attendance calculations during the period of enrollment. Budgets will reflect the applicable year's cost levels for tuition, room and board, transportation, books, supplies, personal expenses, and any other cost factors deemed necessary for consideration, consistent with WAC 250-40-040 (2)(a).

(3) "Total family contribution and resources" shall be consistent with amounts recognized by federal need analysis criteria, unless otherwise modified in accordance with these rules and program guidelines.

(4) "Washington resident" shall be defined as an individual who satisfies the requirements of RCW 28B.15.011 - 28B.15.013 except resident students defined in RCW 28B.15.012 (2)(e) and board-adopted rules and regulations pertaining to the determination of residency.

(5) "Eligible institution of postsecondary education" shall mean any postsecondary educational institution in the state of Washington accredited by the Northwest Association of Schools and Colleges; or a branch campus of a member institution accredited by Middle States Association of Colleges and Schools, New England Association of Schools and Colleges, North Central Association of Colleges and Schools, Southern Association of Colleges and Schools, Northwest Association of Schools and Colleges, or Western Association of Schools and Colleges that is eligible for federal student financial aid assistance and has operated as a nonprofit college or university delivering on-site classroom instruction for a minimum of twenty consecutive years in the state of Washington; or any public technical colleges in the state of Washington.

(6) "Eligible employer" shall be defined as any eligible ((~~public~~)) institution of postsecondary education; any ((~~other~~)) nonprofit organization ((~~which is nonsectarian~~)); or any ((~~profit-making nonsectarian~~)) private sector employer producing a good or providing a service for sale or resale to others, which can and agrees to provide employment of a demonstrable benefit related to the student's postsecondary educational pursuits and which conducts business within the state of Washington; or any other employer approved by the ((~~higher education coordinating board~~)) office. In approving an employer as eligible, the ((~~board~~)) office or an institution acting as its agent will consider at the minimum:

(a) The relationship of the jobs to the students' educational objectives;

(b) The potential for displacement of regular employees;

(c) The rate of pay as compared to salaries and wages provided other employees engaged in similar work; and

(d) The ((~~employer~~)) employer's compliance with ((~~appropriate~~)) applicable federal and state civil rights laws.

(7) "Dependent student" shall mean any post-high school student attending an eligible institution of postsecondary education who does not qualify as an independent student in accordance with subsection (8) of this section.

(8) "Independent student" shall mean any student who qualifies as an independent student for federal student aid.

(9) "Half-time student" means any student enrolled in at least one-half the credit hour or clock hour load defined by the institution as constituting expected full-time progress toward the particular degree or certificate.

(10) "Off-campus community service placements" shall include direct service, planning, or applied research that is designed to improve the quality of life for residents of the community served, particularly low-income residents, in such fields as health care, child care, education, literacy training, welfare, social services, public safety, crime prevention and control, transportation, recreation, housing and neighborhood improvement, rural development, and community improvement. Placements are identified by an institution through formal or informal consultation with local nonprofit, governmental, and community-based organizations.

AMENDATORY SECTION (Amending WSR 06-17-047, filed 8/8/06, effective 9/8/06)

WAC 250-40-050 Restrictions on student placement and compensation. (1) Displacement of employees. Employment of state work-study students may not result in displacement of employed workers or impair existing contracts for services.

(a) State work-study students employed by public institutions of postsecondary education may not fill positions currently or formerly occupied by classified employees.

(b) In cases of governmental employment, state work-study students may fill positions which have been previously occupied but were vacated as a result of implementing previously adopted reduction in force policies in response to employment limitations imposed by federal, state or local governments.

(c) In all other cases, state work-study students may not fill positions which have been occupied by regular employees during the current or prior calendar or fiscal year.

(2) Rate of compensation. All work-study positions shall receive compensation equal to the entry level salary of comparable nonwork-study positions.

Students employed by public postsecondary educational institutions who are filling positions which are comparable to Washington personnel resources board classified positions must be paid entry level Washington personnel resources board wages for the position unless the overall scope and responsibilities of the position indicate a higher level.

Determination of comparability must be made in accordance with state work-study program operational guidelines.

Documentation must be on file at the institution for each position filled by a state work-study student which is deemed

by the institution as not comparable to a higher education personnel board position.

(3) Maximum total state work-study compensation. Earnings beyond the student's state work-study eligibility must be reported to the financial aid officer, and resulting adjustments made in the financial aid package in accordance with federal methodology. In the event that a student earns more money from state work-study employment than the institution anticipated when it awarded student financial aid, the excess is to be treated in accordance with the method specified in the state work-study operational guidelines.

(4) State share of student compensation. With the exception of board-approved off campus community service placements, the state share of compensation paid students shall not exceed 80 percent of the student's gross compensation. In the following cases the state share may be established at 80 percent:

(a) When employed by state supported institutions of postsecondary education at which they are enrolled;

(b) When employed as tutors by the state's common school districts;

(c) When employed in tutorial or other support staff positions by nonprofit adult literacy service providers in the state of Washington who meet guideline criteria for participation; and

(d) When employed in an off-campus community service placement. The state share of compensation paid students employed by all other employers shall not exceed 65 percent of the student's gross compensation.

(5) Employer share of student compensation. The employer shall pay a minimum of 20 percent or 35 percent of the student's gross compensation as specified in subsection (4) of this section, plus the costs of any employee benefits including all payments due as an employer's contribution under the state workman's compensation laws, federal Social Security laws, and other applicable laws. The federal work-study program cannot be used to provide employer share of student compensation except when used for placement of students in tutorial or other support staff positions with adult literacy service providers in the state of Washington who meet guideline criteria for participation.

(6) Academic credit for state work-study employment. Students may receive academic credit for experience gained through state work-study employment.

(7) Maximum hours reimbursed. Employment of a student in excess of an average of 19 hours per week, or in the case of on-campus graduate assistants an average of 20 hours per week, over the period of enrollment for which the student has received an award or a maximum of 40 hours per week during vacation periods will not be eligible for reimbursement from state funds.

A student may not be concurrently employed in the same position by the state work-study program and the federal work-study program and exceed the 19 hours per week average.

(8) Types of work prohibited. Work performed by a student under the state work-study program shall not ((~~be sectarian related~~)) directly involve religious worship, exercise or instruction and shall not involve any partisan or nonpartisan political activity.

(9) Relationship to formula staffing percentage. Placement of state work-study students in on-campus positions at public postsecondary educational institutions may not result in a level of employment in any budget program in excess of a formula staffing percentage specifically mandated by the legislature.

WSR 19-23-063

PERMANENT RULES

HEALTH CARE AUTHORITY

[Filed November 15, 2019, 2:38 p.m., effective January 1, 2020]

Effective Date of Rule: January 1, 2020.

Purpose: The agency is revising these rules to comply with the requirements of SHB 1199. Specifically, the following changes are being made:

WAC 182-511-1000, this rule is being amended to clarify that healthcare for workers with disabilities (HWD) coverage may provide access to long-term services and supports (LTSS), and that approval for LTSS also includes a determination of functional eligibility. If an enrollee is approved for both, then they may choose between paying a monthly premium for HWD or participating in the cost of care according to rules that apply to the specific LTSS program.

WAC 182-511-1050, this rule is being amended to remove the income and age limit.

WAC 182-511-1060, this rule is being repealed as it is no longer applicable. Effective January 1, 2020, there is no income limit.

WAC 182-511-1100, this rule is being amended to allow for the approval of any one month of retroactive coverage for which the full premium amount is paid in advance.

WAC 182-511-1150, this rule is being amended to clarify the disability determination for HWD coverage, including requirements that apply to people who are sixty-five years or older. Statutory authority of the Balanced Budget Act of 1997 is added, which allows people who are sixty-five years or older to enroll, if they meet all program requirements that include having blindness or a disability.

WAC 182-511-1200, this rule is being amended to clarify work activity that meets program requirements for people who are self-employed.

WAC 182-511-1250, this rule is being amended to clarify that the monthly premium amount shall not exceed 7.5 percent of countable income. Also, to allow payment for retroactive coverage, if paid separately, to be applied before payment for a current coverage month.

WAC 182-512-0550, this rule is being amended to exclude as a resource the funds held in a separate account that include only the income of a client earned during the time of enrollment in HWD. If the account is maintained separately, its value shall be excluded as a resource when determining the client's subsequent eligibility for another medical assistance program.

Citation of Rules Affected by this Order: Repealing WAC 182-511-1060; and amending WAC 182-511-1000, 182-511-1050, 182-511-1100, 182-511-1150, 182-511-1200, 182-511-1250, and 182-512-0550.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160; SHB 1199 (chapter 70, Laws of 2019).

Adopted under notice filed as WSR 19-20-083 on September 30, 2019.

Changes Other than Editing from Proposed to Adopted Version: Updated the reference in WAC 182-511-1250(9) from WAC 182-511-1050 (4)(b) to 182-511-1050 (3)(b).

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 7, Repealed 1.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 7, Repealed 1.

Date Adopted: November 15, 2019.

Wendy Barcus
Rules Coordinator

Chapter 182-511 WAC

((~~HEALTH CARE~~)) APPLE HEALTH FOR WORKERS WITH DISABILITIES (HWD)

AMENDATORY SECTION (Amending WSR 15-14-080, filed 6/29/15, effective 7/30/15)

WAC 182-511-1000 Apple health ((~~care~~)) for workers with disabilities (HWD)—Program description. This section describes the apple health ((~~care~~)) for workers with disabilities (HWD) program.

(1) The HWD program provides categorically needy (CN) scope of care as described in WAC 182-501-0060.

(2) The HWD program also provides long-term services and supports described in chapters 182-513 and 182-515 WAC for a client who meets the functional requirements for those programs, are approved for those services, and choose to enroll in HWD.

(3) The medicaid agency approves HWD coverage for twelve months effective the first of the month in which a person applies and meets program requirements. See WAC 182-511-1100 for ((~~"~~))retroactive((~~"~~)) coverage for months before the month of application.

(((~~3~~))) (4) A person who is eligible for another medicaid program may choose not to participate in the HWD program.

(((~~4~~))) (5) A person is not eligible for HWD coverage for a month in which the person received medicaid benefits under the medically needy (MN) program.

(((~~5) The HWD program does not provide long-term care (LTC) services described in chapters 182-513 and 182-515 WAC. LTC services include institutional, waivered, and hospice services. To receive LTC services, a person must qualify and participate in the cost of care according to the rules of those programs.~~))

AMENDATORY SECTION (Amending WSR 15-14-080, filed 6/29/15, effective 7/30/15)

WAC 182-511-1050 Apple health ((~~care~~)) for workers with disabilities (HWD)—Program requirements. This section describes requirements a person must meet to be eligible for the apple health ((~~care~~)) for workers with disabilities (HWD) program.

(1) To qualify for the HWD program, a person must:

(a) Meet the general requirements for a medical program described in WAC 182-503-0505 (3)(a) through (f);

(b) Be at least age sixteen ((~~through sixty-four~~));

(c) Meet the federal disability requirements described in WAC 182-511-1150; and

(d) ((~~Have net income at or below two hundred twenty percent of the federal poverty level (FPL) (see WAC 182-511-1060 for FPL amounts for medical programs); and~~

~~(e)~~)) Be employed full or part time (including self-employment) as described in WAC 182-511-1200.

(2) ((~~To determine net income, the medicaid agency applies the following rules to total gross household income in this order:~~

~~(a) Deduct income exclusions described in WAC 182-512-0800, 182-512-0820, 182-512-0840, and 182-512-0860; and~~

~~(b) Follow the CN income rules described in:~~

~~(i) WAC 182-512-0600, SSI-related medical—Definition of income;~~

~~(ii) WAC 182-512-0650, SSI-related medical—Available income;~~

~~(iii) WAC 182-512-0700 (1) through (5), SSI-related medical—Income eligibility;~~

~~(iv) WAC 182-512-0750, SSI-related medical—Countable unearned income; and~~

~~(v) WAC 182-512-0960, SSI-related medical clients.~~

~~(3)~~)) The HWD program does not require ((~~an asset~~)) a resource test.

(((~~4~~))) (3) Once approved for HWD coverage, a person must pay the monthly premium in ((~~the following manner to continue to qualify for the program:~~)) order to continue to qualify.

(a) The agency calculates the premium for HWD coverage according to WAC 182-511-1250((~~;~~)).

(b) If a person does not pay four consecutive monthly premiums, the person is not eligible for HWD coverage for the next four months and must pay all premium amounts owed before HWD coverage can be approved again((~~; and~~)).

(c) Once approved for HWD coverage, a person who experiences a job loss can choose to continue HWD coverage through the original twelve months of eligibility, if the following requirements are met:

(i) The job loss results from an involuntary dismissal or health crisis; and

(ii) The person continues to pay the monthly premium.

AMENDATORY SECTION (Amending WSR 15-14-080, filed 6/29/15, effective 7/30/15)

WAC 182-511-1100 Apple health ((~~care~~)) for workers with disabilities (HWD)—Retroactive coverage. This section describes requirements for retroactive coverage provided under the apple health ((~~care~~)) for workers with disabilities (HWD) program.

(1) Retroactive coverage refers to the period of up to three months before the month in which a person applies for the HWD program. ((~~The medicaid agency cannot approve HWD coverage for a month that precedes January 1, 2002.~~))

(2) To qualify for retroactive coverage under the HWD program, a person must first:

(a) Meet all program requirements described in WAC 182-511-1050 for each month of the retroactive period; and

(b) Pay the premium amount for each month requested within one hundred twenty days of being billed for such coverage.

(3) ((~~If a person does not pay premiums in full as described in subsection (2)(b) for all months requested in the retroactive period, the agency denies retroactive coverage and refunds any payment received for those months.~~)) Payment must be received for each month requested of retroactive coverage before such coverage is approved.

AMENDATORY SECTION (Amending WSR 19-08-025, filed 3/27/19, effective 4/27/19)

WAC 182-511-1150 Apple health ((~~care~~)) for workers with disabilities (HWD)—Disability requirements. This section describes the disability requirements for the ((~~two~~)) following groups of individuals ((~~that~~)) who may qualify for the apple health ((~~care~~)) for workers with disabilities (HWD) program.

(1) ((~~To qualify for the HWD program,~~)) A person age sixteen through age sixty-four must meet the requirements of the Social Security Act in section 1902(a)(10)(A)(ii):

(a) (XV) for the basic coverage group (BCG); or

(b) (XVI) for the medical improvement group (MIG).

(2) The BCG consists of individuals who:

(a) Meet federal disability requirements for the supplemental security income (SSI) or Social Security Disability Insurance (SSDI) program; or

(b) Are determined by the department of social and health services (DSHS), division of disability determination services (DDDS), to meet federal disability requirements for the HWD program.

(3) The MIG consists of individuals who:

(a) Were previously eligible and approved for the HWD program as a member of the BCG; and

(b) Are determined by DDDS to have a medically improved disability. The term "medically improved disability" refers to the particular status granted to persons described in subsection (1)(b). For these people, a continuation of HWD coverage is provided to help them maintain their employment.

(4) A person age sixty-five or older, must meet federal disability requirements as determined by the DSHS DDDS. Coverage under the MIG is not available under federal law for persons age sixty-five or older. Coverage for this age group is authorized under the Balanced Budget Act of 1997 as described under section 1902 (a)(10)(A)(ii)(XIII).

(5) When completing a disability determination for the HWD program, DDDS will not ((~~deny disability status because of employment~~)) determine a person not disabled based only on earnings or the performance of substantial gainful activity (SGA). (See SSA POMS Section DI 10501.001, https://secure.ssa.gov/apps10/poms.nsf/lnx/0410501001).

AMENDATORY SECTION (Amending WSR 11-24-018, filed 11/29/11, effective 12/1/11)

WAC 182-511-1200 Apple health ((~~care~~)) for workers with disabilities (HWD)—Employment requirements. This section describes the employment requirements for the basic coverage group (BCG) and the medical improvement group (MIG) for the apple health ((~~care~~)) for workers with disabilities (HWD) program.

(1) For the purpose of the HWD program, employment means a person:

(a) Gets paid for working;

(b) Has earnings that are subject to federal income tax; and

(c) Has payroll taxes taken out of earnings received, unless self-employed.

(2) To qualify for HWD coverage as a member of the BCG, a person must be employed full or part time.

(3) To qualify for HWD coverage as a member of the MIG, a person must be:

(a) Working at least forty hours per month; and

(b) Earning at least the local minimum wage as described under section 6 of the Fair Labor Standards Act (29 U.S.C. 206).

(4) For a person who is self-employed, the examples described in the *Social Security Administration Program Operations Manual System (POMS)* provide guidance when determining whether someone meets the HWD work requirements. (See SSA POMS Section SI 00820.200, http://secure.ssa.gov/poms.nsf/lnx/0500820200). The guidelines described in POMS for determining the existence of a trade or business may also be used when making this determination. (See SSA POMS Section RS 01802.010, https://secure.ssa.gov/apps10/poms.nsf/lnx/0301802010).

AMENDATORY SECTION (Amending WSR 15-14-080, filed 6/29/15, effective 7/30/15)

WAC 182-511-1250 Apple health ((~~care~~)) for workers with disabilities (HWD)—Premium payments. This section describes how the medicaid agency calculates the premium amount a person must pay for apple health ((~~care~~)) for workers with disabilities (HWD) coverage. This section also describes program requirements regarding the billing and payment of HWD premiums.

(1) When determining the HWD premium amount, the agency counts only the income of the person approved for the program. It does not count the income of another household member.

(2) When determining countable income used to calculate the HWD premium, the agency applies the following rules:

(a) Income is considered available and owned when it is:

(i) Received; and

(ii) Can be used to meet the person's needs for food, clothing, and shelter, except as described in WAC 182-512-0600(5), 182-512-0650, and 182-512-0700(1).

(b) ((Loans and certain other)) Certain receipts are not ((considered to be)) income as described in 20 C.F.R. Sec. 416.1103((, e.g., direct payment by anyone of a person's medical insurance premium or a tax refund on income taxes already paid)).

(3) The HWD premium amount equals the lesser of the two following amounts:

(a) A total of the following (rounded down to the nearest whole dollar):

(((a))) (i) Fifty percent of unearned income above the medically needy income level (MNIL) described in WAC 182-519-0050; plus

(((b))) (ii) Five percent of total unearned income; plus

(((c))) (iii) Two ((point five)) and one-half percent of earned income after first deducting sixty-five dollars; or

(b) Seven and one-half percent of countable income described in subsection (2) of this section, including both earned and unearned income.

(4) When determining the premium amount, the agency will use the ((current)) currently verified income amount until a change in income is reported and processed, unless good cause for delay in verifying changes exists.

(5) A change in the premium amount is effective the month after the change in income is reported and processed.

(6) For current and ongoing coverage, the agency will bill for HWD premiums during the month following the benefit month ((in which coverage is approved)).

(7) For retroactive coverage, the agency will bill the HWD premiums during the month following the month in which coverage is requested and necessary information ((is received)) that establishes eligibility is received by the agency.

(8) If initial coverage for the HWD program is approved in a month that follows the month of application, the first monthly premium includes the costs for both the month of application and any following ((month(s))) months that have passed during determination of eligibility.

(9) As described in WAC 182-511-1050 (((4))) (3)(b), the agency will close HWD coverage ((after four consecutive months for which premiums are not paid in full.

(10) If a person makes only a partial payment toward the cost of HWD coverage for any one month, the person remains one full month behind in the payment schedule.

(11) The agency first applies payment for current and ongoing coverage to any amount owed for such coverage in an earlier month. Then it applies payment to the current month and then to any unpaid amount for retroactive coverage)) if premiums are not paid in full for four consecutive months.

(10) The person must pay the monthly premium in full to avoid losing HWD coverage. If a person makes a partial payment, the payment does not count as a full payment toward the premium.

(11) Payments received are applied to premiums owed in the following order:

(a) If retroactive coverage is requested, the retroactive coverage month(s);

(b) Past due months, beginning with the most delinquent month;

(c) The current coverage month that has been invoiced; then

(d) Future coverage months.

(12) A person must pay a premium for any month that HWD coverage is provided. This includes months when a redetermination of coverage is made, and months when continued coverage that is requested, pending the outcome of an administrative hearing.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 182-511-1060	Washington apple health—Health care for workers with disabilities (HWD)—Income standard based on the federal poverty guidelines.

AMENDATORY SECTION (Amending WSR 19-13-010, filed 6/6/19, effective 7/7/19)

WAC 182-512-0550 SSI-related medical—All other excluded resources. All resources described in this section are excluded resources for SSI-related medical programs. Unless otherwise stated, interest earned on the resource amount is counted as unearned income.

(1) Resources necessary for a person who is blind or disabled to fulfill a self-sufficiency plan approved by the agency.

(2) Retroactive payments from SSI or old age, survivors, and disability insurance (OASDI), including benefits a person receives under the interim assistance reimbursement agreement with the Social Security Administration, are excluded for nine months following the month of receipt. This exclusion applies to:

(a) Payments received by the person, the person's spouse, or any other person financially responsible for the person;

(b) SSI payments for benefits due for the month(s) before the month of continuing payment;

(c) OASDI payments for benefits due for a month that is two or more months before the month of continuing payment; and

(d) Proceeds from these payments as long as they are held as cash, or in a checking or savings account. The funds may be commingled with other funds, but must remain identifiable from the other funds for this exclusion to apply. This exclusion does not apply once the payments have been converted to any other type of resource.

(3) All resources specifically excluded by federal law, such as those described in subsections (4) through (11) of this section as long as such funds are identifiable.

(4) Payments made under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.

(5) The excluded resources described in WAC 182-512-0770 and other resources of American Indians/Alaska Natives that are excluded by federal law.

(6) Restitution payment and any interest earned from this payment to persons of Japanese or Aleut ancestry who were relocated and interned during war time under the Civil Liberties Act of 1988 and the Aleutian and Pribilof Islands Restitution Act.

(7) Funds received from the Agent Orange Settlement Fund or any other funds established to settle Agent Orange liability claims.

(8) Payments or interest accrued on payments received under the Radiation Exposure Compensation Act received by the injured person, the surviving spouse, children, grandchildren, or grandparents.

(9) Payments or interest accrued on payments received under the Energy Employees Occupational Illness Compensation Act of 2000 (EEOICA) received by the injured person, the surviving spouse, children, grandchildren, or grandparents.

(10) Payments from:

(a) The Dutch government under the Netherlands' Act on Benefits for Victims of Persecution (WUV).

(b) The Victims of Nazi Persecution Act of 1994 to survivors of the Holocaust.

(c) Susan Walker vs. Bayer Corporation, et al., 96-C-5024 (N.D. Ill.) (May 8, 1997) settlement funds.

(d) Ricky Ray Hemophilia Relief Fund Act of 1998 P.L. 105-369.

(11) The unspent social insurance payments received due to wage credits granted under sections 500 through 506 of the Austrian General Social Insurance Act.

(12) Tax refunds and earned income tax credit refunds and payments are excluded as resources for twelve months after the month of receipt.

(13) Payments from a state administered victim's compensation program for a period of nine calendar months after the month of receipt.

(14) Cash or in-kind items received as a settlement for the purpose of repairing or replacing a specific excluded resource are excluded:

(a) For nine months. This includes relocation assistance provided by state or local government.

(b) Up to a maximum of thirty months, when:

(i) The person intends to repair or replace the excluded resource; and

(ii) Circumstances beyond the control of the settlement recipient prevented the repair or replacement of the excluded resource within the first or second nine months of receipt of the settlement.

(c) For an indefinite period, if the settlement is from federal relocation assistance.

(d) Permanently, if the settlement is assistance received under the Disaster Relief and Emergency Assistance Act or other assistance provided under a federal statute because of a catastrophe which is declared to be a major disaster by the President of the United States, or is comparable assistance received from a state or local government or from a disaster assistance organization. Interest earned on this assistance is also excluded from resources. Any cash or in-kind items received as a settlement and excluded under this subsection are available resources when not used within the allowable time periods.

(15) Insurance proceeds or other assets recovered by a Holocaust survivor.

(16) Pension funds owned by an ineligible spouse. Pension funds are defined as funds held in a(n):

(a) Individual retirement account (IRA) as described by the IRS code; or

(b) Work-related pension plan (including plans for self-employed persons, known as Keogh plans).

(17) Cash payments received from a medical or social service agency to pay for medical or social services are excluded for one calendar month following the month of receipt.

(18) SSA- or division of vocational rehabilitation (DVR)-approved plans for achieving self-support (PASS) accounts, allowing blind or disabled persons to set aside resources necessary for the achievement of the plan's goals, are excluded.

(19) Food and nutrition programs with federal involvement. This includes Washington Basic Food, school reduced and free meals and milk programs and WIC.

(20) Gifts to, or for the benefit of, a person under eighteen years old who has a life-threatening condition, from an organization described in section 501 (c)(3) of the Internal Revenue Code of 1986 which is exempt from taxation under section 501(a) of that code, as follows:

(a) In-kind gifts that are not converted to cash; or

(b) Cash gifts up to a total of two thousand dollars in a calendar year.

(21) Veteran's payments made to, or on behalf of, natural children of Vietnam veterans regardless of their age or marital status, for any disability resulting from spina bifida suffered by these children.

(22) The following are among assets that are not resources and as such are neither excluded nor counted:

(a) Home energy assistance/support and maintenance assistance;

(b) Retroactive in-home supportive services payments to ineligible spouses and parents; and

(c) Gifts of domestic travel tickets.

(23) ((~~For a more complete list, please see the program operations manual system (POMS) at http://policy.ssa.gov/poms.nsf/lnx/0501130050.~~)) Resources accumulated in a separate account, designated by the client, that result from work activity during the client's enrollment in apple health for workers with disabilities (HWD) program under chapter 182-511 WAC.

(24) Resources listed in the program operations manual system (POMS), not otherwise excluded under this section, are excluded (see SSA POMS Section SI 01130.050 http://secure.ssa.gov/apps10/poms.nsf/lnx/0501130050).

WSR 19-23-071
PERMANENT RULES
GAMBLING COMMISSION

[Filed November 18, 2019, 1:29 p.m., effective December 19, 2019]

Effective Date of Rule: Thirty-one days after filing.

Purpose: Current raffle and licensing rules do not distinguish credit unions from other nonprofits even though there are some differences in organizational structure. The gambling commission needed to adopt new rules and amend an existing rule to allow credit unions to conduct raffles. Specifically, these rules were adopted to outline the requirements a credit union must follow in order to conduct a raffle, identify when a license to conduct a raffle by a credit union must be obtained, and outline what information must be provided by a credit union when applying for a raffle license.

Citation of Rules Affected by this Order: New WAC 230-11-013 Conducting a raffle by a credit union and 230-03-146 Applying for a raffle license by a credit union.

Statutory Authority for Adoption: RCW 9.46.070.

Adopted under notice filed as WSR 19-19-074 on September 17, 2019.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 2, Amended 0, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 2, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: November 14, 2019.

Ashlie Laydon
Rules Coordinator

NEW SECTION

WAC 230-03-146 Applying for a raffle license by a credit union. Credit unions may apply for a raffle-credit union license to operate raffles, as authorized under RCW 9.46.0209(2) and 9.46.0315. The credit union must provide:

(1) Proof they are currently a federally or state chartered credit union located in Washington and are in good standing; and

(2) Official meeting minutes of the organization for the last twelve months demonstrating they are in the business for nongambling purposes; and

(3) A listing of the names of the director, board chair, and board as defined in WAC 208-400-020; and

(4) A section in their bylaws or their articles of incorporation guaranteeing that, if the organization is dissolved, all raffle revenues less prizes and expenses must be distributed to a charitable and nonprofit organization as set out in RCW 9.46.0209(1); and

(5) A listing of the charitable and nonprofit organizations as set out in RCW 9.46.0209(1) receiving all raffle revenues less prizes and expenses; and

(6) Any additional information requested by us.

NEW SECTION

WAC 230-11-013 Conducting a raffle by a credit union. The following requirements apply when a credit union organized and operating under state or federal law conducts a raffle:

(1) All revenue received from raffles, less prizes and expenses, must be devoted to purposes authorized in RCW 9.46.0209(1); and

(2) Tickets for such raffles can be sold only to, and winners are determined only from among, the regular members of the credit union; and

(3) All recordkeeping requirements outlined in this chapter must be met; and

(4) A license must be obtained if gross revenues from all such raffles held by the credit union during a calendar year exceed five thousand dollars.

WSR 19-23-080
PERMANENT RULES
DEPARTMENT OF LABOR AND INDUSTRIES

[Filed November 19, 2019, 10:27 a.m., effective January 1, 2020]

Effective Date of Rule: January 1, 2020.

Purpose: The department amends WAC 296-17-870 Evaluation of actual losses, an employer's experience rating is a factor in determining rates they pay for workers' compensation insurance. The date of injury is a factor in determining the experience rating. Adopting this change codifies the department's practice to use the date a claim is received as the date of injury for an occupational disease claim for experience rating purposes.

Citation of Rules Affected by this Order: Amending WAC 296-17-870.

Statutory Authority for Adoption: RCW 51.04.020 and 51.16.035.

Adopted under notice filed as WSR 19-19-067 on September 17, 2019.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 1, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 1, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: November 19, 2019.

Joel Sacks
Director

AMENDATORY SECTION (Amending WSR 13-11-128, filed 5/21/13, effective 7/1/13)

WAC 296-17-870 Evaluation of actual losses. (1) Except as provided in subsections (3) through (12) of this section, the actual losses for claims with a date of injury during the experience period will be evaluated on the "valuation date." Losses on claims occurring outside the experience period will not be included. The actual losses for closed claims must include:

(a) Accident and medical aid payments; and

(b) Pension reserve amounts paid by the accident fund; and

(c) Accident and medical aid benefits or payments that are scheduled to be paid; and

(d) Reserve for other accident and medical aid benefits accessible by the worker while the claim is closed.

The actual losses for claims that are open may, in addition, also include a reserve for future payments. Actual losses do not include wage subsidies or reimbursements paid by the stay-at-work program.

(2) **Valuation date.** The valuation date shall be June 1, seven months immediately preceding the effective date of premium rates.

(3) **Retroactive adjustments - Revision of losses between valuation dates.** No claim value shall be revised between valuation dates and no retroactive adjustment of an experience modification shall be made because of disputation concerning the judgment of the claims examiner or because of subsequent developments except as specifically provided in the following cases:

(a) In cases where loss values are included or excluded through mistake other than error of judgment.

(b) In cases where a third party recovery is made, subject to subsection (5)(a) of this section.

(c) In cases where the claim qualifies as a second injury claim under the provisions of RCW 51.16.120.

(d) In cases where a claim, which was previously evaluated as a compensable claim, is closed and is determined to be noncompensable (ineligible for benefits other than medical treatment).

(e) In cases where a claim is closed and is determined to be ineligible for any benefits.

In the above specified cases retroactive adjustment of the experience modification shall be made for each rating in which the claim was included. Retroactive adjustments will not be made for rating periods more than ten years prior to the date on which the claim status was changed.

(4) **Average death value.** Each fatality occurring to a worker included within the mandatory or elective coverage of Title 51 RCW shall be assigned the "average death value." The "average death value" shall be the average incurred cost for all such fatalities occurring during the experience period. The average death value is set forth in WAC 296-17-880 (Table II).

(5) **Third-party recovery - Effect on experience modification.**

(a) For claims with injury dates prior to July 1, 1994, a potential claim cost recovery from action against a third party, either by the injured worker or by the department, shall not be considered in the evaluation of actual losses until such time as the third-party action has been completed. If a third-party recovery is made after a claim had previously been used in an experience modification calculation, the experience modification shall be retroactively adjusted. The department shall compute a percentage recovery by dividing the current valuation of the claim into the amount recovered or recoverable as of the recovery date, and shall reduce both primary and excess losses previously used in the experience modification calculation by that percentage.

(b) For claims with injury dates on or after July 1, 1994, if the department determines that there is a reasonable potential of recovery from an action against a third party, both primary and excess values of the claim shall be reduced by fifty percent for purposes of experience modification calculation, until such time as the third-party action has been completed. This calculation shall not be retroactively adjusted, regardless of the final outcome of the third-party action. After a third-party recovery is made, the actual percentage recovery shall be applied to future experience modification calculations.

(c) For third-party actions completed before July 1, 1996, the claim shall be credited with the department's net share of the recovery, after deducting attorney fees and costs. For third-party actions completed on or after July 1, 1996, the claim shall be credited with the department's gross share of the recovery, before deducting attorney fees and costs.

(d) Definitions:

(i) As used in this section, "recovery date" means the date the money is received at the department or the date the order confirming the distribution of the recovery becomes final, whichever comes first.

(ii) As used in this section, "recoverable" means any amount due as of the recovery date and/or any amount available to offset case reserved future benefits.

(6) **Second injury claims.** The primary and excess values of any claim which becomes eligible for second injury relief under the provisions of RCW 51.16.120, as now or hereafter amended, shall be reduced by the percentage of relief granted.

(7) **Occupational disease claims.** When a claim results from an employee's exposure to an occupational disease hazard, the "date of injury," solely for the purpose of experience rating, will be the date the ((~~disability was diagnosed and that gave rise to the filing of a~~)) claim for benefits was received by the department. The cost of any occupational disease claim, paid from the accident fund and medical aid fund and arising from exposure to the disease hazard under two or more employers, shall be prorated to each period of employment involving exposure to the hazard. Each insured employer who had employed the claimant during the experience period, and for at least ten percent of the claimant's exposure to the

hazard, shall be charged for his/her share of the claim based upon the prorated costs.

(8) **Maximum claim value.** No claim shall enter an employer's experience record at a value greater than the "maximum claim value." The maximum claim value is set forth in WAC 296-17-880 (Table II).

(9) **Catastrophic losses.** Whenever a single accident results in the deaths or total permanent disability of three or more workers employed by the same employer, costs charged to the employer's experience shall be limited as required by RCW 51.16.130.

(10) **Acts of terrorism.** Whenever any worker insured with the state fund sustains an injury or occupational disease as a result of an incident certified to be an act of terrorism under the U.S. Terrorism Risk Insurance Act of 2002, the costs of the resulting claim shall be excluded from the experience rating computation of the worker's employer.

(11) **Claims filed by preferred workers.** The costs of subsequent claims filed by certified preferred workers will not be included in experience calculations, as provided in WAC 296-16-150.

(12) **Life and rescue phase of emergencies:** This provision applies to "emergency workers" of nongovernmental employers assigned to report in classification 7205 (WAC 296-17A-7205) who assist in a life and rescue phase of a state or local emergency (disaster). The life and rescue phase of an emergency is defined in RCW 51.16.130(3) as being the first seventy-two hours after a natural or man-made disaster has occurred. For an employer to qualify for this special experience rating relief, a state or local official such as, but not limited to, the governor; a county executive; a mayor; a fire marshal; a sheriff or police chief must declare an emergency and must request help from private sector employers to assist in locating and rescuing survivors. This special relief is only applicable to nongovernmental employers during this initial seventy-two hour phase of the declared emergency unless the emergency has been extended by the official who declared the emergency. The cost of injuries or occupational disease claims filed by employees of nongovernmental employers assisting in the life and rescue phase of a declared emergency will not be charged to the experience record of the nongovernmental state fund employer.

WSR 19-23-085
PERMANENT RULES
OFFICE OF THE INSURANCE COMMISSIONER

[Filed November 19, 2019, 11:36 a.m., effective December 20, 2019]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The purpose of this rule is to adopt rules necessary to implement and administer the Balance Billing Protection Act (BBPA) (chapter 427, Laws of 2019), ensuring that consumers are protected from wrongful balance billing.

Citation of Rules Affected by this Order: New WAC 284-43B-010 through 284-43B-080; and amending WAC 284-170-480.

Statutory Authority for Adoption: RCW 48.02.060, 48.49.060, 48.49.110.

Adopted under notice filed as WSR 19-20-112 on October 2, 2019.

Changes Other than Editing from Proposed to Adopted Version: The final rule differs from the proposed rule in two respects.

The proposed rule included a definition of "same or similar geographic area" in WAC 284-43B-010. It defined the term as the geographic methodology adopted for the all-payer claims database (APCD) data set developed under RCW 43.371.100. The office of the insurance commissioner (OIC) received multiple comments indicating that this methodology was intended to apply to development of the database, and that it was not appropriate to apply it to carriers' calculation of consumer cost-sharing under WAC 284-43B-020(1) or to establishment of commercially reasonable amounts under WAC 284-43B-030. Designation of geographic areas for purposes of calculating in-network provider payment rates would be inconsistent with BBPA, which directs carriers to use their median in-network rates as a basis for calculating enrollee cost-sharing. Carriers have established geographic regions in place for purposes of calculating their in-network and out-of-network provider payment rates. For these reasons, and awareness of the upcoming January 1, 2020, effective date of BBPA, the final rule does not include a definition of "same or similar geographic area." However, the APCD dataset will utilize the OIC geographic rating areas established in WAC 284-43-6701 for purposes of determining median allowed amount and median billed charge amounts in the database.

The final rule revises the language of WAC 284-43B-050(4) to make a technical clarification regarding the provider network contracts that are to be posted by health care providers and facilities on their websites.

A final cost-benefit analysis is available by contacting Tabba Alam, P.O. Box 40360, Olympia, WA 98502, phone 360-725-7170, email TabbaA@oic.wa.gov, website www.insurance.wa.gov.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 8, Amended 1, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: November 19, 2019.

Mike Kreidler
Insurance Commissioner

Chapter 284-43B WAC

BALANCE BILLING

NEW SECTION

WAC 284-43B-010 Definitions. (1) The definitions in RCW 48.43.005 apply throughout this chapter unless the context clearly requires otherwise, or the term is defined otherwise in subsection (2) of this section.

(2) The following definitions shall apply throughout this chapter:

(a) "Allowed amount" means the maximum portion of a billed charge a health carrier will pay, including any applicable enrollee cost-sharing responsibility, for a covered health care service or item rendered by a participating provider or facility or by a nonparticipating provider or facility.

(b) "Balance bill" means a bill sent to an enrollee by an out-of-network provider or facility for health care services provided to the enrollee after the provider or facility's billed amount is not fully reimbursed by the carrier, exclusive of permitted cost-sharing.

(c) "Emergency medical condition" means a medical, mental health, or substance use disorder condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain or emotional distress, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical, mental health, or substance use disorder treatment attention to result in a condition (i) placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

(d) "Emergency services" means a medical screening examination, as required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate that emergency medical condition, and further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient. Stabilize, with respect to an emergency medical condition, has the meaning given in section 1867 (e)(3) of the Social Security Act (42 U.S.C. 1395dd (e)(3)).

(e) "Facility" means a hospital licensed under chapter 70.41 RCW or an ambulatory surgical facility licensed under chapter 70.230 RCW.

(f) "In-network" or "participating" means a provider or facility that has contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to enrollees and be reimbursed by the carrier at a contracted rate as payment in full for the health care services, including applicable cost-sharing obligations. A single case reimbursement agreement between a provider or facility and a carrier used for the purpose described in WAC 284-170-200 constitutes a contract exclusively for purposes of this definition under the Balance Billing Protection Act and is limited to the services and parties to the agreement.

(g) "Median in-network contracted rate for the same or similar service in the same or similar geographical area" means the median amount negotiated for an emergency or surgical or ancillary service for participation in the carrier's health plan network with in-network providers of emergency or surgical or ancillary services furnished in the same or similar geographic area. If there is more than one amount negotiated with the health plan's in-network providers for the emergency or surgical or ancillary service in the same or similar geographic area, the median in-network contracted rate is the median of these amounts. In determining the median described in the preceding sentence, the amount negotiated for each claim for the same or similar service with each in-network provider is treated as a separate amount (even if the same amount is paid to more than one provider or to the same provider for more than one claim). If no per-service amount has been negotiated with any in-network providers for a particular service, the median amount must be calculated based upon the service that is most similar to the service provided. For purposes of this subsection "median" means the middle number of a sorted list of reimbursement amounts negotiated with in-network providers with respect to a certain emergency or surgical or ancillary service, with each paid claim's negotiated reimbursement amount separately represented on the list, arranged in order from least to greatest. If there is an even number of items in the sorted list of negotiated reimbursement amounts, the median is found by taking the average of the two middlemost numbers.

(h) "Offer to pay," "carrier payment," or "payment notification" means a claim that has been adjudicated and paid by a carrier to an out-of-network or nonparticipating provider for emergency services or for surgical or ancillary services provided at an in-network facility.

(i) "Out-of-network" or "nonparticipating" means a provider or facility that has not contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to enrollees.

(j) "Provider" means a person regulated under Title 18 RCW or chapter 70.127 RCW to practice health or health-related services or otherwise practicing health care services in this state consistent with state law, or an employee or agent of a person acting in the course and scope of his or her employment, that provides emergency services, or surgical or ancillary services at an in-network facility.

(k) "Surgical or ancillary services" means surgery, anesthesiology, pathology, radiology, laboratory, or hospitalist services.

NEW SECTION

WAC 284-43B-020 Balance billing prohibition and consumer cost-sharing. (1) If an enrollee receives any emergency services from an out-of-network facility or provider, or any nonemergency surgical or ancillary services at an in-network facility from an out-of-network provider:

(a) The enrollee satisfies his or her obligation to pay for the health care services if he or she pays the in-network cost-sharing amount specified in the enrollee's or applicable group's health plan contract. The enrollee's obligation must be determined using the carrier's median in-network con-

tracted rate for the same or similar service in the same or similar geographical area. The carrier must provide an explanation of benefits to the enrollee and the out-of-network provider that reflects the cost-sharing amount determined under this subsection.

(b) The carrier, out-of-network provider, or out-of-network facility, and any agent, trustee, or assignee of the carrier, out-of-network provider, or out-of-network facility must ensure that the enrollee incurs no greater cost than the amount determined under (a) of this subsection.

(c)(i) For emergency services provided to an enrollee, the out-of-network provider or out-of-network facility, and any agent, trustee, or assignee of the out-of-network provider or out-of-network facility may not balance bill or otherwise attempt to collect from the enrollee any amount greater than the amount determined under (a) of this subsection. This does not impact the provider's ability to collect a past due balance for an applicable in-network cost-sharing amount with interest;

(ii) For emergency services provided to an enrollee in an out-of-network hospital located and licensed in Oregon or Idaho, the carrier must hold an enrollee harmless from balance billing; and

(iii) For nonemergency surgical or ancillary services provided at an in-network facility, the out-of-network provider and any agent, trustee, or assignee of the out-of-network provider may not balance bill or otherwise attempt to collect from the enrollee any amount greater than the amount determined under (a) of this subsection. This does not impact the provider's ability to collect a past due balance for an applicable in-network cost-sharing amount with interest.

(d) For emergency services and nonemergency surgical or ancillary services provided at an in-network facility, the carrier must treat any cost-sharing amounts determined under (a) of this subsection paid or incurred by the enrollee for an out-of-network provider or facility's services in the same manner as cost-sharing for health care services provided by an in-network provider or facility and must apply any cost-sharing amounts paid or incurred by the enrollee for such services toward the enrollee's maximum out-of-pocket payment obligation.

(e) If the enrollee pays an out-of-network provider or out-of-network facility an amount that exceeds the in-network cost-sharing amount determined under (a) of this subsection, the provider or facility must refund any amount in excess of the in-network cost- sharing amount to the enrollee within thirty business days of the provider or facility's receipt of the enrollee's payment. Simple interest must be paid to the enrollee for any unrefunded payments at a rate of twelve percent per annum beginning on the first calendar day after the thirty business days.

(2) The carrier must make payments for health care services described in section 6, chapter 427, Laws of 2019, provided by an out-of-network provider or facility directly to the provider or facility, rather than the enrollee.

(3) A health care provider or facility, or any of its agents, trustees or assignees may not require a patient at any time, for any procedure, service, or supply, to sign or execute by electronic means, any document that would attempt to avoid, waive, or alter any provision of this section.

NEW SECTION

WAC 284-43B-030 Out-of-network claim payment and dispute resolution. The allowed amount paid to an out-of-network provider for health care services described under section 6, chapter 427, Laws of 2019, shall be a commercially reasonable amount, based on payments for the same or similar services provided in the same or a similar geographic area.

(1) Within thirty calendar days of receipt of a claim from an out-of-network provider or facility, the carrier shall offer to pay the provider or facility a commercially reasonable amount. Payment of an adjudicated claim shall be considered an offer to pay. The amount actually paid to an out-of-network provider by a carrier may be reduced by the applicable consumer cost-sharing determined under WAC 284-43B-020 (1)(a). The date of receipt by the provider or facility of the carrier's offer to pay is five calendar days after a transmittal of the offer is mailed to the provider or facility, or the date of transmittal of an electronic notice of payment. The claim submitted by the out-of-network provider or facility to the carrier must include the following information:

(a) Patient name;

(b) Patient date of birth;

(c) Provider name;

(d) Provider location;

(e) Place of service, including the name and address of the facility in which, or on whose behalf, the service that is the subject of the claim was provided;

(f) Provider federal tax identification number;

(g) Federal Center for Medicare and Medicaid Services individual national provider identifier number, and organizational national provider identifier number, if the provider works for an organization or is in a group practice that has an organization number;

(h) Date of service;

(i) Procedure code; and

(j) Diagnosis code.

(2) If the out-of-network provider or facility wants to dispute the carrier's offer to pay, the provider or facility must notify the carrier no later than thirty calendar days after receipt of the offer to pay or payment notification from the carrier. A carrier may not require a provider or facility to reject or return payment of the adjudicated claim as a condition of putting the payment into dispute.

(3) If the out-of-network provider or facility disputes the carrier's offer to pay, the carrier and provider or facility have thirty calendar days after the provider or facility receives the offer to pay to negotiate in good faith.

(4) If the carrier and the out-of-network provider or facility do not agree to a commercially reasonable payment amount within the thirty-calendar day period under subsection (3) of this section, and the carrier, out-of-network provider or out-of-network facility chooses to pursue further action to resolve the dispute, the dispute shall be resolved through arbitration, as provided in section 8, chapter 427, Laws of 2019.

(5)(a) To initiate arbitration, the carrier, provider, or facility must provide written notification to the commissioner and the noninitiating party no later than ten calendar days following completion of the period of good faith negotiation under subsection (3) of this section. The written notification

to the commissioner must be made electronically and provide dates related to each of the time period limitations described in subsections (1) through (4) of this section.

(b) If an out-of-network provider or out-of-network facility chooses to address multiple claims in a single arbitration proceeding as provided in section 8, chapter 427, Laws of 2019, notification must be provided no later than ten calendar days following completion of the period of good faith negotiation under subsection (3) of this section for the most recent claim that is to be addressed through the arbitration. All of the claims at issue must:

(i) Involve identical carrier and provider or facility parties;

(ii) Involve claims with the same or related current procedural terminology codes relevant to a particular procedure; and

(iii) Occur within a two month period of one another, such that the earliest claim that is the subject of the arbitration occurred no more than two months prior to the latest claim that is the subject of the arbitration. For purposes of this subsection, a provider or facility claim occurs on the date the service is provided to a patient or, in the case of inpatient facility admissions, the date the admission ends.

(c) A notification submitted to the commissioner later than ten calendar days following completion of the period of good faith negotiation will be considered untimely and will be rejected. A party that has submitted an untimely notice is permanently foreclosed from seeking arbitration related to the claim or claims that were the subject of the untimely notice.

(d) Within seven calendar days of receipt of notification from the initiating party, the commissioner must provide the parties with a list of approved arbitrators or entities that provide arbitration. The arbitrator selection process must be completed within twenty calendar days of receipt of the original list of arbitrators from the commissioner, as follows:

(i) If the parties are unable to agree on an arbitrator from the original list sent by the commissioner, they must notify the commissioner within five calendar days of receipt of the original list of arbitrators. The commissioner must send the parties a list of five arbitrators within five calendar days of receipt of notice from the parties under this subsection.

(ii) If, after the opportunity to veto up to two of the five named arbitrators on the list of five arbitrators sent by the commissioner to the parties, more than one arbitrator remains on the list, the parties must notify the commissioner within five calendar days of receipt of the list of five arbitrators. The commissioner will choose the arbitrator from among the remaining arbitrators on the list.

(e) For purposes of this subsection, the date of receipt of a list of arbitrators is the date of electronic transmittal of the list to the parties by the commissioner. The date of receipt of notice from the parties to the commissioner is the date of electronic transmittal of the notice to the commissioner by the parties.

(6) If a noninitiating party fails to timely respond without good cause to a notice initiating arbitration, the initiating party will choose the arbitrator.

NEW SECTION

WAC 284-43B-040 Determining whether an enrollee's health plan is subject to the requirements of the act. To implement section 7, chapter 427, Laws of 2019, carriers must make information regarding whether an enrollee's health plan is subject to the requirements of chapter 427, Laws of 2019, available to providers and facilities using the most current version of the Health Insurance Portability and Accountability Act (HIPAA) mandated X12 Health Care Eligibility Benefit Response (271) transaction information through use of a standard message that is placed in a standard location within the 271 transaction. The designated lead organization for administrative simplification in Washington state, after consultation with carriers, providers and facilities through a new or an existing workgroup or committee, must post the language of the standard message and the location within the 271 transaction in which the message is to be placed on its website on or before November 1, 2019. This information also must be posted on the website of the office of the insurance commissioner.

NEW SECTION

WAC 284-43B-050 Notice of consumer rights and transparency. (1) The commissioner shall develop a standard template for a notice of consumer rights under the Balance Billing Protection Act. The notice may be modified periodically, as determined necessary by the commissioner. The notice template will be posted on the public website of the office of the insurance commissioner.

(2) The standard template for the notice of consumer rights under the Balance Billing Protection Act must be provided to consumers enrolled in any health plan issued in Washington state as follows:

(a) Carriers must:

(i) Include the notice in the carrier's communication to an enrollee, in electronic or any other format, that authorizes nonemergency surgical or ancillary services at an in-network facility;

(ii) Post the notice on their website in a prominent and relevant location, such as in a location that addresses coverage of emergency services and prior authorization requirements for nonemergency surgical or ancillary services performed at in-network facilities; and

(iii) Provide the notice to any enrollee upon request.

(b) Health care facilities and providers must:

(i) For any facility or provider that is owned and operated independently from all other businesses and that has more than fifty employees, upon confirming that a patient's health plan is subject to the Balance Billing Protection Act, include the notice in any communication to a patient, in electronic or any other format, confirming the scheduling of nonemergency surgical or ancillary services at a facility;

(ii) Post the notice on their website, if the provider or facility maintains a website, in a prominent and relevant location near the list of the carrier health plan provider networks with which the provider or facility is an in-network provider; and

(iii) Provide the notice upon request of a patient.

(3) For claims processed on or after July 1, 2020, when processing a claim that is subject to the balance billing prohibition in section 6, chapter 427, Laws of 2019, the carrier must indicate on any form used by the carrier to notify enrollees of the amount the carrier has paid on the claim:

(a) Whether the claim is subject to the prohibition in the act; and

(b) The federal Center for Medicare and Medicaid Services individual national provider identifier number, and organizational national provider identifier number, if the provider works for an organization or is in a group practice that has an organization number.

(4) A facility or health care provider meets its obligation under section 11 or 12, chapter 427, Laws of 2019, to include a listing on its website of the carrier health plan provider networks in which the facility or health care provider participates by posting this information on its website for in-force contracts, and for newly executed contracts within fourteen calendar days of receipt of the fully executed contract from a carrier. If the information is posted in advance of the effective date of the contract, the date that network participation will begin must be indicated.

(5) Not less than thirty days prior to executing a contract with a carrier, a hospital or ambulatory surgical facility must provide the carrier with a list of the nonemployed providers or provider groups that have privileges to practice at the hospital or ambulatory surgical facility or are contracted to provide surgical or ancillary services at the hospital or ambulatory surgical facility. The list must include the name of the provider or provider group, mailing address, federal tax identification number or numbers and contact information for the staff person responsible for the provider's or provider group's contracting. The hospital or ambulatory surgical facility must notify the carrier within thirty days of a removal from or addition to the nonemployed provider list. A hospital or ambulatory surgical facility also must provide an updated list of these providers within fourteen calendar days of a written request for an updated list by a carrier.

(6) An in-network provider must submit accurate information to a carrier regarding the provider's network status in a timely manner, consistent with the terms of the contract between the provider and the carrier.

NEW SECTION

WAC 284-43B-060 Enforcement. (1) If the commissioner has cause to believe that any health facility or provider has engaged in a pattern of unresolved violations of section 6 or 7, chapter 427, Laws of 2019, the commissioner may submit information to the department of health or the appropriate disciplining authority for action.

(2) In determining whether there is cause to believe that a health care provider or facility has engaged in a pattern of unresolved violations, the commissioner shall consider, but is not limited to, consideration of the following:

(a) Whether there is cause to believe that the health care provider or facility has committed two or more violations of section 6 or 7, chapter 427, Laws of 2019;

(b) Whether the health care provider or facility has failed to submit claims to carriers containing all of the elements required in WAC 284-43B-030(1) on multiple occasions, putting a consumer or consumers at risk of being billed for services to which the prohibition in section 6, chapter 427, Laws of 2019 applies;

(c) Whether the health care provider or facility has been nonresponsive to questions or requests for information from the commissioner related to one or more complaints alleging a violation of section 6 or 7, chapter 427, Laws of 2019; and

(d) Whether, subsequent to correction of previous violations, additional violations have occurred.

(3) Prior to submitting information to the department of health or the appropriate disciplining authority, the commissioner may provide the health care provider or facility with an opportunity to cure the alleged violations or explain why the actions in question did not violate section 6 or 7, chapter 427, Laws of 2019.

NEW SECTION

WAC 284-43B-070 Self-funded group health plan opt in. (1) A self-funded group health plan that elects to participate in sections 6 through 8, chapter 427, Laws of 2019, shall provide notice to the commissioner of their election decision on a form prescribed by the commissioner. The completed form must include an attestation that the self-funded group health plan has elected to participate in and be bound by sections 6 through 8, chapter 427, Laws of 2019. The form will be posted on the commissioner's public website for use by self-funded group health plans.

(2) A self-funded group health plan may elect to initiate its participation on January 1st of any year or in any year on the first day of the self-funded group health plan's plan year.

(3) A self-funded group health plan's election occurs on an annual basis. On its election form, the plan must indicate whether it chooses to affirmatively renew its election on an annual basis or whether it should be presumed to have renewed on an annual basis until the commissioner receives advance notice from the plan that it is terminating its election as of either December 31st of a calendar year or the last day of its plan year. Notices under this subsection must be submitted to the commissioner at least thirty days in advance of the effective date of the election to initiate participation and the effective date of the termination of participation.

(4) Self-funded group health plan sponsors and their third party administrators may develop their own internal processes related to member notification, member appeals and other functions associated with their fiduciary duty to enrollees under the Employee Retirement Income Security Act of 1974 (ERISA).

NEW SECTION

WAC 284-43B-080 Effective date. Chapter 284-43B WAC takes effect on January 1, 2020.

AMENDATORY SECTION (Amending WSR 16-14-106, filed 7/6/16, effective 8/6/16)

WAC 284-170-480 Participating provider—Filing and approval. (1) An issuer must file for prior approval all participating provider agreements and facility agreements

thirty calendar days prior to use. If a carrier negotiates a provider or facility contract or a compensation agreement that deviates from an approved agreement, then the issuer must file that negotiated contract or agreement with the commissioner for approval thirty days before use. The commissioner must receive the filings electronically in accordance with chapters 284-44A, 284-46A, and 284-58 WAC.

(2)(a) An issuer may file a provider or facility contract template with the commissioner. A "contract template" is a sample contract and compensation agreement form that the issuer will use to contract with multiple providers or facilities. A contract template must be issued exactly as approved.

(i) When an issuer modifies the contract template, an issuer must refile the modified contract template for approval. All changes to the contract template must be indicated through strike outs for deletions and underlines for new material. The modified template must be issued to providers and facilities upon approval.

(ii) Alternatively, issuers may file the modified contract template for prospective contracting and a contract addendum or amendment that would be issued to currently contracted providers or facilities for prior approval. The filing must include any correspondence that will be sent to a provider or facility that explains the amendment or addendum. The correspondence must provide sufficient information to clearly inform the provider or facility what the changes to the contract will be. All changes to the contract template must be indicated through strike outs for deletions and underlines for new material.

(iii) Changes to a previously filed and approved provider compensation agreement modifying the compensation amount or terms related to compensation must be filed and are deemed approved upon filing if there are no other changes to the previously approved provider contract or compensation agreement.

(b)(i) All negotiated contracts and compensation agreements must be filed with the commissioner for approval thirty calendar days prior to use and include all contract documents between the parties.

(ii) If the only negotiated change is to the compensation amount or terms related to compensation, it must be filed and is deemed approved upon filing.

(3) If the commissioner takes no action within thirty calendar days after submission, the form is deemed approved except that the commissioner may extend the approval period an additional fifteen calendar days upon giving notice before the expiration of the initial thirty-day period. Approval may be subsequently withdrawn for cause.

(4) The issuer must maintain provider and facility contracts at its principal place of business in the state, or the issuer must have access to all contracts and provide copies to facilitate regulatory review upon twenty days prior written notice from the commissioner.

(5) Nothing in this section relieves the issuer of the responsibility detailed in WAC 284-170-280 (3)(b) to ensure that all provider and facility contracts are current and signed if the provider or facility is listed in the network filed for approval with the commissioner.

(6) If an issuer enters into a reimbursement agreement that is tied to health outcomes, utilization of specific services, patient volume within a specific period of time, or other performance standards, the issuer must file the reimbursement agreement with the commissioner thirty days prior to the effective date of the agreement, and identify the number of enrollees in the service area in which the reimbursement agreement applies. Such reimbursement agreements must not cause or be determined by the commissioner to result in discrimination against or rationing of medically necessary services for enrollees with a specific covered condition or disease. If the commissioner fails to notify the issuer that the agreement is disapproved within thirty days of receipt, the agreement is deemed approved. The commissioner may subsequently withdraw such approval for cause.

(7) Provider contracts and compensation agreements must clearly set forth the carrier provider networks and applicable compensation agreements associated with those networks so that the provider or facility can understand their participation as an in-network provider and the reimbursement to be paid. The format of such contracts and agreements may include a list or other format acceptable to the commissioner so that a reasonable person will understand and be able to identify their participation and the reimbursement to be paid as a contracted provider in each provider network.

WSR 19-23-090
PERMANENT RULES
EMPLOYMENT SECURITY DEPARTMENT

[Filed November 19, 2019, 3:45 p.m., effective December 20, 2019]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The employment security department (ESD) is responsible for implementing the paid family and medical leave program in accordance with Title 50A RCW. Rule making is being done in several distinct phases. In this phase, ESD includes rules regarding clarification of definitions, assessing and collecting premiums, typical workweek hours, implementing legislative changes, and appeals.

Citation of Rules Affected by this Order: New WAC 192-500-180, 192-510-031, 192-530-090, 192-600-030, 192-610-051, 192-610-052, 192-620-026, 192-620-030, 192-620-035, 192-620-040, 192-620-045, 192-620-046, 192-800-025, 192-800-030, 192-800-035, 192-800-040, 192-800-045, 192-800-050, 192-800-055, 192-800-060, 192-800-065, 192-800-070, 192-800-075, 192-800-080, 192-800-085, 192-800-090, 192-800-095, 192-800-100, 192-800-105, 192-800-110, 192-800-115, 192-800-120, 192-800-125 and 192-800-150; repealing WAC 192-800-002 and 192-800-003; and amending WAC 192-500-035, 192-500-040, 192-510-030, 192-510-066, 192-510-080, 192-530-030, 192-530-050, 192-530-060, 192-560-010, 192-570-010, and 192-610-050.

Statutory Authority for Adoption: RCW 50A.04.215.

Adopted under notice filed as WSR 19-19-005 on September 5, 2019.

A final cost-benefit analysis is available by contacting Christina Streulil [Streuli], Employment Security Department, P.O. Box 9046, Olympia, WA 98507-9046, phone 360-791-6710, TTY WA relay 711 (contact Teresa Eckstein at 360-507-9890 for accommodations), email cstreuli@esd.

wa.gov, website online portal https://www.peakdemocracy.com/portals/289/forum_home?phase=open.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 34, Amended 11, Repealed 2.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: November 19, 2019.

April Amundson
Policy and Rules Manager

AMENDATORY SECTION (Amending WSR 18-22-080, filed 11/2/18, effective 12/3/18)

WAC 192-500-035 Interested parties. (1) In all determinations, cases, and appeals adjudicated under Title 50A RCW the employment security department is an "interested party."

(2) Other interested parties in paid family or medical leave determinations related to the state plan and appeals include:

(a) The employee or former employee; and

(b) An employer or former employer of that employee that is required to provide information to the department related to the determination or appeal in question.

(3) Other interested parties in paid family or medical leave determinations related to ((~~a~~)) an approved voluntary plan include:

(a) The employer or former employer; and

(b) An employee or former employee ((~~that is required to provide information to the department related to the determination or appeal in question~~)).

(4) ((~~Other interested parties in a determination related to a small business assistance grant include the employer requesting the grant.~~)) The department may designate an employee or employer as an interested party in other determinations made by the department.

AMENDATORY SECTION (Amending WSR 18-22-080, filed 11/2/18, effective 12/3/18)

WAC 192-500-040 Aggrieved person. An "aggrieved person" is any interested party who receives an adverse decision from:

(1) The department for which the department has provided notice of appeal;

(2) The employer with an approved voluntary plan for which that employer has provided notice of appeal;

(3) The office of administrative hearings; or

((~~(3)~~)) (4) The commissioner's review office.

NEW SECTION

WAC 192-500-180 Supplemental benefit payment. (1) A "supplemental benefit payment" is a payment offered by an employer to an employee who is taking leave under Title 50A RCW.

(2) Employers may, but are not required to, designate certain benefits including, but not limited to, salary continuation, vacation leave, sick leave, or other paid time off as a supplemental benefit.

(3) Nothing in Title 50A RCW requires an employee to receive supplemental benefit payments.

AMENDATORY SECTION (Amending WSR 18-12-032, filed 5/29/18, effective 6/29/18)

WAC 192-510-030 How will the department determine the wages earned and hours worked for self-employed persons electing coverage? (1) The department will use the self-employed person's wages reported ((~~income~~)) in a quarter and divide it by the state's minimum wage to presume the number of hours worked for the quarter being reported.

((~~**Example:** For this example, the state's minimum wage is $12.00 per hour. The self-employed person electing coverage reports $10,000 of income in a quarter. The department will divide $10,000 by $12.00 and presume the self-employed person worked 833 hours in that quarter.~~))

(2) The self-employed person may overcome the presumption of hours in subsection (1) of this section by providing sufficient documentation to the department including, but not limited to, personal logs or contracts.

(3) If the determination of hours in subsection (1) or (2) of this section is greater than eight hundred twenty hours for that quarter, the number of hours worked will be considered eight hundred twenty hours.

Example: For this example, the state's minimum wage is $12.00 per hour. The self-employed person electing coverage reports $10,000 in wages in a quarter. The department will divide $10,000 by $12.00 and presume the self-employed person worked 833 hours in that quarter. The department will determine that the self-employed individual worked 820 hours in that quarter.

(4) The department may require copies of tax returns, bank records, or any other documentation deemed necessary by the department to verify or determine the self-employed person's hours and wages.

NEW SECTION

WAC 192-510-031 What are reportable wages for self-employed persons electing coverage? Each quarter, a self-employed individual who has elected coverage under Title 50A RCW will report to the department wages equal to the combined total of:

(1) The self-employed individual's net income related to their self-employment; and

(2) The gross amount of wages, if any, as defined in RCW 50A.05.010(24), paid to the self-employed individual from the self-employed individual's business entity.

Example 1: A sole-proprietor selling crafts online earns $3,000 in a quarter and incurred $2,000 in business-related expenses. The individual would report $1,000 to the department for that quarter.

Example 2: A member of a limited liability company pays herself a salary in the amount of $10,000 in a quarter. She also takes a draw from her company in the amount of $5,000. She would report $15,000 to the department for that quarter.

AMENDATORY SECTION (Amending WSR 18-22-080, filed 11/2/18, effective 12/3/18)

WAC 192-510-066 How are ((~~premium~~)) payments applied to paid family and medical leave premiums? (1) A payment received with a premium assessment will be applied to the quarter for which the premium assessment ((~~is filed~~)) applies. A payment exceeding the legal fees, penalties, interest and premiums due for that quarter will be applied to any other debt as provided in subsection ((~~(2)~~)) (4) of this section.

(2) If no debt exists, ((~~a refund will be issued for any~~)) premium overpayments of less than fifty dollars ((~~or more~~)) will be credited to future payments due.

(3) If no debt exists, premium overpayments of ((~~less than~~)) fifty dollars or more may be refunded to the employer at the employer's request. Otherwise, such overpayments will be credited to future ((~~premium assessments~~)) payments due.

((~~(2)~~)) (4) Payments received will be applied in the following order of priority:

(a) ((~~Most recently completed quarter's premium~~)) Current quarter balance;

(b) Any previous quarter premium balance due starting with the oldest quarter;

(c) Then beginning with the oldest quarter in which a balance is owed:

(i) Penalties;

(ii) Fees; and

(iii) Interest charges.

AMENDATORY SECTION (Amending WSR 18-12-032, filed 5/29/18, effective 6/29/18)

WAC 192-510-080 What are the requirements to be eligible for a conditional premium waiver? (1) An employer and employee may be eligible for a conditional waiver of premium payments by satisfying the requirements of RCW ((~~50A.04.120~~)) 50A.10.040.

Example: A storm hits Washington. An employer in Oregon hires a new employee who lives in Oregon to help with repair work. The employee only works in Washington for the employer for one week and is then laid off. The employer and the employee could submit a conditional premium waiver request for this employee.

(2) A conditional premium waiver is not required for work that is not subject to premiums under WAC 192-510-070 or fails to meet the definition of employment in RCW ((~~50A.04.010~~)) 50A.05.010 (7)(a).

(3) Any conditional premium waiver request must be submitted to the department online or in another format approved by the department.

(4) As a condition to granting the conditional premium waiver, the employer must file quarterly reports to verify that the employee((~~s~~)) for whom a conditional premium waiver has been granted is still ((~~qualify for the conditional premium~~)) eligible for the waiver.

(5) Once an employee works eight hundred twenty hours in a ((~~qualifying~~)) period of four consecutive complete calendar quarters localized in Washington for an employer, the conditional premium waiver expires.

(6) The department may require the employer to submit additional documentation as necessary.

(7) If the employee exceeds eight hundred twenty hours ((~~or more~~)) in a ((~~qualifying~~)) period of four consecutive complete calendar quarters, the conditional waiver expires and the employer and employee will be responsible for their shares of all premiums that would have been paid during the ((~~qualifying~~)) period of four consecutive complete calendar quarters in which the employee exceeded eight hundred twenty hours had the waiver not been granted. The employer and employee will each receive a notice of premium assessment. Payment of the missed premiums is due on the date provided in the notice. Upon payment of the missed premiums, the employee will be credited for the hours worked and will be eligible for benefits under this chapter as if the premiums were originally paid.

((~~**Example:** A storm hits Washington. An employer in Oregon hires a new employee who lives in Oregon to help with repair work. The employee only works in Washington for the employer for one week and is then laid off. The employer could request a conditional premium waiver for this employee.~~))

(8) A request for a conditional premium waiver may be denied if the department finds that the employee does not satisfy the requirements of RCW 50A.10.040.

(9) A conditional premium waiver may be canceled if the department finds that the employee no longer satisfies the requirements of RCW 50A.10.040.

AMENDATORY SECTION (Amending WSR 18-12-032, filed 5/29/18, effective 6/29/18)

WAC 192-530-030 Voluntary plans—Employee eligibility criteria. (1) To qualify for an employer's approved voluntary plan, an employee must have been:

(a) In employment for at least eight hundred twenty hours during the qualifying period and in employment with that employer for at least three hundred forty hours; or

(b) Covered by an approved voluntary plan through their most recent previous employer in the employee's qualifying period.

(2) An employer may waive the requirements of subsection (1) of this section, in whole or in part, to allow an employee to be eligible for benefits through the voluntary plan.

(3) Employees working for an employer with a voluntary plan who have not yet met eligibility requirements for that

plan are eligible for benefits under the state plan so long as all other requirements are met.

((~~(3)~~)) (4) When an employee files a claim for benefits, an employer will access the employee's weekly benefit amount and typical workweek hours information online, or in another format approved by the department, and ensure the employee qualifies for at least an equivalent benefit amount from its voluntary plan.

((~~(4)~~)) (5) Upon hiring an employee previously covered under a state plan, the employer with an existing voluntary plan must report to the department online, or in another format approved by the department, the new employee's status for the voluntary plan after the employee becomes eligible for that plan.

AMENDATORY SECTION (Amending WSR 18-12-032, filed 5/29/18, effective 6/29/18)

WAC 192-530-050 Avoiding a duplication of benefits under state and approved voluntary plans. (1) Employees cannot collect benefits from both the state plan and ((~~a~~)) an approved voluntary plan for the same period. To ensure compliance, employers with an approved voluntary plan must report:

(a) All information required of employers by the state plan; and

(b) Weekly benefit and leave duration information for any employee who takes leave under that plan for reasons that would have qualified for leave under the state plan((~~; and~~

~~(c) Premiums, if any, withheld from employee wages~~)).

(2) Upon request, the department will provide weekly benefit, typical workweek hours, and leave duration information to any employer with an approved voluntary plan that requests it for an employee who intends to take leave under that plan.

(3) If the employee is covered by more than one plan, whether state, voluntary, or a combination of either, the employee is considered covered by the employer for which the employee worked the most hours during the qualifying period.

(a) If the employee worked an equal number of hours for more than one employer during the qualifying period, then the employee is considered covered by the employer for which the employee worked the most hours since the qualifying period.

(b) If the employee worked an equal number of hours for more than one employer since the qualifying period, then the employee is considered covered by the employer for which the employee has an earlier start date.

AMENDATORY SECTION (Amending WSR 18-22-080, filed 11/2/18, effective 12/3/18)

WAC 192-530-060 ((~~What happens at the end of a voluntary plan?~~)) How can approved voluntary plans end and what happens when they do? ((~~(1) If the employer chooses to withdraw from a voluntary plan due to a legally required increase in the benefit amounts or any change in the rate of employee premiums, the employer must provide notice to the department at least thirty days prior to the date that the change goes into effect. The plan will be considered withdrawn on the date of the change. The employer must remit any deductions from the wages of an employee remaining in the possession of the employer to the department within thirty days of the effective date of the withdrawal.~~

~~(2)(a) If the employer chooses to withdraw from a voluntary plan for any other reason, the employer must provide notice to the department at least thirty days prior to the end of a calendar quarter. The plan will be considered withdrawn on the first day of the following calendar quarter.~~

~~(b) If notice is provided less than thirty days prior to the end of a quarter, the plan will be considered withdrawn on the first day of the second calendar quarter following notice of the withdrawal.~~

~~(c) The employer must remit any deductions from the wages of an employee remaining in the possession of the employer to the department within thirty days of the effective date of the withdrawal.~~

~~(3) If the department terminates an employer's voluntary plan, the department will notify the employer of the effective date and the reason for termination. The department will calculate the amount owed by the employer and send an invoice for payment. The amount due will consist of all moneys in the plan, including premiums paid by the employer, premiums paid by the employees, moneys owed to the voluntary plan by the employer but not yet paid to the plan, and any interest accrued on all these moneys. The amount will be due immediately. Any balance owed will not start collecting interest until thirty calendar days after the date of the invoice.~~

~~(4) Benefit eligibility under a voluntary plan must be maintained for all employees covered by that plan until the effective date of termination or withdrawal.~~

~~(a) On the effective date of a voluntary plan termination, employees currently receiving paid family or medical leave benefits are, if otherwise eligible, immediately entitled to benefits from the state program.~~

~~(b) For employees currently receiving paid family or medical leave benefits on the effective date of a voluntary plan withdrawal, the employer will have the option to:~~

~~(i) Continue to pay benefits under the terms of the voluntary plan until the total amount of the benefit is paid or the duration of leave ends, whichever happens first; or~~

~~(ii) Immediately pay the employee the maximum remaining amount of benefits available to the employee under the terms of the voluntary plan, regardless of the duration of leave that is actually taken.~~

~~(c) On the effective date of a voluntary plan termination or withdrawal, employees currently taking family or medical leave under this chapter are, if otherwise eligible, entitled to the job protection provisions of RCW 50A.04.600(5) until the duration of leave ends.~~

~~(5) Employers are required to notify employees of any plan withdrawal or termination within five business days of notification by the department of the effective date of termination or withdrawal.~~)) (1) An approved voluntary plan ends when either the employer withdraws the plan or the agency terminates the plan for good cause. When a voluntary plan ends either through termination or withdrawal the following requirements must be satisfied:

(a) Benefits and benefit eligibility under a voluntary plan must be maintained for all employees covered by that plan until the effective date of termination or withdrawal.

(b) On the effective date of a voluntary plan termination or withdrawal, employees currently taking family or medical leave under this chapter are entitled to employment restoration under RCW 50A.30.010 (5)(h) until the leave ends.

(c) Employers must notify employees of any plan withdrawal or termination within five business days of notification by the department of the effective date of the termination or withdrawal.

(2) **Withdrawal.** Employers have the right to withdraw a voluntary plan under RCW 50A.30.010 (5)(e) and as provided herein:

(a) If an employer chooses to withdraw a voluntary plan due to a legally required increase in the benefit amounts or any change in the rate of employee premiums, the employer must provide notice to the department at least thirty days prior to the date the change goes into effect, stating the reason for the withdrawal. The plan will be considered withdrawn on the date of the change. Within thirty days of the effective date of withdrawal, the employer must remit to the department any employee wages withheld for the purpose of paying paid family or medical leave benefits that were not used to pay paid family or medical leave benefits.

(b) If the employer chooses to withdraw a voluntary plan for any other reason, the employer must provide notice to the department at least thirty days prior to the end of a calendar quarter. The plan will be considered withdrawn on the first day of the calendar quarter following the properly provided notice. If notice is provided less than thirty days prior to the end of a quarter, the plan will be considered withdrawn on the first day of the second calendar quarter following notice of the withdrawal. Within thirty days of the effective date of withdrawal, the employer must remit to the department any employee wages withheld for the purpose of paying paid family or medical leave benefits that were not used to pay paid family or medical leave benefits.

(c) On the effective date of a voluntary plan withdrawal, for employees currently receiving paid family or medical leave benefits under the voluntary plan, the employer will have the option to:

(i) Continue to pay benefits under the terms of the voluntary plan until the total amount of the benefit is paid or the duration of leave ends, whichever happens first; or

(ii) Immediately pay the employee the maximum remaining amount of benefits available to the employee under the terms of the voluntary plan, regardless of the duration of leave that is actually taken.

(d) Any benefit payments made by an employer to an employee on leave at the time of a voluntary plan withdrawal under (b) of this subsection will be deducted from any moneys owed to the department as described in (a) of this subsection.

(3) **Termination.** The department may terminate an employer's voluntary plan for good cause as defined under WAC 192-530-070 and as provided herein:

(a) If the department terminates an employer's voluntary plan, the department will notify the employer of the effective date of and reason for the termination. The department will calculate the amount owed by the employer and send an invoice for payment. The amount due will consist of all moneys in the plan, including any contributions held in trust as required by RCW 50A.30.050, moneys owed to the voluntary plan by the employer but not yet paid to the plan, and any interest accrued on all these moneys. The amount is due immediately. Any balance owed will begin accruing interest on the thirtieth calendar day after the date of the invoice.

(b) On the effective date of a voluntary plan termination, employees currently receiving paid family or medical leave benefits under the voluntary plan are, if otherwise eligible under the state plan, immediately entitled to benefits from the state plan.

NEW SECTION

WAC 192-530-090 Can an employer with an approved voluntary plan make deductions from a benefit payment? Employers are permitted, with express written agreement from the employee, to make deductions from voluntary plan benefit payments including, but not limited to, health insurance premium payments, retirement contributions, applicable federal taxes, or other purposes, unless prohibited by law.

AMENDATORY SECTION (Amending WSR 18-22-080, filed 11/2/18, effective 12/3/18)

WAC 192-560-010 Which businesses are eligible for small business assistance grants? (1) Employers determined to have one hundred fifty or fewer employees in the state that are assessed the employer share of the premium are eligible to apply for small business assistance grants.

(2) Employers determined to have fewer than fifty employees are only eligible ((~~to apply~~)) for a small business assistance grant if ((~~they~~)) those employers opt to pay the employer share of the premiums. ((~~The~~)) Such employers will be assessed the employer share of the premium for a minimum of three years after any grant is received. An employer may provide notice for opting out after the three-year period.

(3) An employer is not eligible for a small business assistance grant if, at the time of application, the employer has outstanding and delinquent reports, outstanding and delinquent payments, or due and owing penalties or interest under Title 50A RCW.

(4) An employer may request only one grant per year for each ((~~period of~~)) employee who takes paid family or medical leave ((~~taken by an employee~~)) under this title. Submissions under (a) and (b) of this subsection do not qualify as grant applications and therefore do not count against the employer's limit of ten applications per year.

(a) An employer that qualifies for a grant under RCW ((~~50A.04.230~~)) 50A.24.010 (3)(b) for an amount that is less than one thousand dollars may submit documentation of significant additional wage-related costs incurred after filing the initial grant application in an attempt to qualify for additional grant funds.

(b) An employer may submit a revised application for a grant under RCW ((~~50A.04.230~~)) 50A.24.010 (3)(c) in an attempt to qualify for additional grant funds.

((~~(4)~~)) (5) An employer must apply for the grant no later than four months following the last day of the employee's paid family or medical leave.

AMENDATORY SECTION (Amending WSR 18-22-080, filed 11/2/18, effective 12/3/18)

WAC 192-570-010 Conference and conciliation. (1)(a) The department will engage employers in conference and conciliation when the employer fails to make all required:

(i) Premium payments;

(ii) Payments on penalties assessed by the department for the failure to submit required reports; or

(iii) Payments on penalties assessed by the department for violations related to voluntary plans.

(b) "Conference and conciliation" for the purpose of this chapter means to encourage an amicable resolution of disputes between the employer and the department prior to the issuance of a warning letter.

(2) The department will promptly attempt to contact the employer to engage in conference and conciliation when appropriate under subsection (1) of this section. If the department does not receive a response from the employer by the deadline given, the department will attempt the contact again, for a total of two attempts. A warning letter will be sent to the employer if no contact can be made.

(3)(a) Through conference and conciliation employers will be given an opportunity to provide information and to explain their reasons for failing to meet the department's requirements in subsection (1) of this section. The department will not issue a warning letter if:

(i) The employer provides good cause;

(ii) The department determines ((~~that~~)) the good cause provided prevented compliance; and

(iii) The parties agree to an approved ((~~repayment~~)) payment schedule.

(b) "Good cause" for the purpose of this section means:

(i) Death or serious illness of one or more persons directly responsible for discharging the employer's duties under Title 50A RCW;

(ii) Destruction of the employer's place of business or business records not caused by, or at the direction of, the employer; or

(iii) Fraud or theft against the employer.

(4) The burden of proof is on the employer to provide all pertinent facts and evidence or documentation for the department to determine good cause.

(5) Conference and conciliation is only available to employers ((~~that meet the requirements of RCW 50A.04.080, 50A.04.090, and 50A.04.655. Those employers that do not meet these requirements will be issued a warning letter without entering conference and conciliation. Penalties and interest will be assessed thereafter under Title 50A RCW and the rules adopted pursuant thereto~~)) in the circumstances described in subsection (1)(a) of this section.

(6) If an employer is eligible for conference and conciliation, the department will issue a warning letter when:

(a) The employer does not comply with the approved repayment schedule; or

(b) A resolution is not reached through conference and conciliation.

NEW SECTION

WAC 192-600-030 Can an employer waive the employee's notice requirements? Employers may waive the notice requirements of this chapter.

AMENDATORY SECTION (Amending WSR 19-08-016, filed 3/22/19, effective 4/22/19)

WAC 192-610-050 How are typical workweek hours determined? (1) The department determines typical workweek hours based on whether the employee is salaried or otherwise at the time of filing the initial application for benefits.

(a) For salaried employees, as defined in WAC 192-500-100, the typical workweek hours are forty hours, regardless of the number of hours worked in ((~~a week are assumed to be forty, regardless of how many hours are actually worked. Typical workweek hours are determined by multiplying the number of weeks in the qualifying period the employee held the salaried position by forty, adding any other hours that were not salaried, if any, and then dividing that amount by fifty-two.~~

~~(2)~~)) the employee's qualifying period.

(b) For all other employees, the department will determine typical workweek hours ((~~are determined~~)) by dividing the sum of all hours reported in the qualifying period by fifty-two and rounded down to the nearest hour.

(2) For a qualifying period that includes the fourth quarter of 2018, the typical workweek hours for an employee described in subsection (1)(b) of this section will be determined by dividing the sum of all hours reported in the first three quarters of 2019 by thirty-nine.

NEW SECTION

WAC 192-610-051 How is the weekly benefit calculated? After a valid claim year is established, the department will calculate the weekly benefit amount using the following process:

(1) The department will establish the employee's average weekly wage by dividing the total reported wages in the employee's two highest-paid quarters in the qualifying period by twenty-six. If the result is not a multiple of one dollar, the result is rounded down to the next lower multiple of one dollar.

(2) If the employee's average weekly wage is equal to or less than one-half of the state's average weekly wage on the date the calculation is made, the benefit amount is ninety percent of the employee's average weekly wage.

Example 1: For this example, the state's average weekly wage is $1,400. An employee's average weekly wage is $600. Since this amount is less than half of the state's average weekly wage, the employee receives 90% of their weekly wage. The weekly benefit is $540.

(3) If the employee's average weekly wage is more than fifty percent of the state's average weekly wage on the date the calculation is made, the weekly benefit amount is the sum of:

(a) Ninety percent of one-half of the state average weekly wage; and

(b) Fifty percent of the difference between one-half of the state average weekly wage and the employee's average weekly wage.

Example 2: For this example, the state's average weekly wage is $1,400. An employee's average weekly wage is $950. Since this number is more than half of the state's average weekly wage, calculate the values for subsection (3)(a) and (b) of this section, then add them together. The first number is equal to 90% of half the state's average weekly wage. Half of $1,400 is $700, and 90% of this number makes the first number $630. The second number is equal to 50% of the amount of the employee's average weekly wage that is higher than half the state's average weekly wage. The amount of the employee's average weekly wage that is higher than half the state's average weekly wage is $250 ($950 - $700). 50% of this amount makes the second number $125. Add the two numbers together. The weekly benefit is $755.

(4) If the result of the weekly benefit calculation is not a multiple of one dollar, the result is rounded down to the next lower multiple of one dollar.

(5) All weekly benefit amount calculations are subject to the minimum and maximum weekly benefit amounts under RCW 50A.15.020 (5)(a) and (b).

(6) The weekly benefit amount determined in subsections (1) through (4) of this section is prorated by the number of hours claimed for paid family or medical leave compared to the number of typical workweek hours.

Example 3: An employee has a weekly benefit amount determined to be $1,000. The employee worked 20 hours each week in the qualifying period. The employee is now full-time and salaried, causing the department to consider that employee's typical workweek hours to be 40. The employee can claim 40 hours on each weekly claim. No proration would occur because the hours claimed compared to the typical workweek hours are the same. As a result, the employee would receive 100% of their weekly benefit amount.

NEW SECTION

WAC 192-610-052 How will the department obtain wages and hours that have not yet been reported by employers? If an employee's qualifying period includes a quarter for which the employer has not yet submitted a report to the department, the department will contact the employer to request the employee's hour and wage information for that quarter.

NEW SECTION

WAC 192-620-026 What is the maximum amount of paid family or medical benefits to which an employee is entitled in a claim year? (1) In any given claim year, an employee is not entitled to paid family or medical leave benefit payments that exceed an amount equal to:

(a) The employee's weekly benefit amount multiplied by twelve for family leave;

(b) The employee's weekly benefit amount multiplied by twelve for medical leave; or

(c) The employee's weekly benefit amount multiplied by sixteen for a combination of family and medical leave.

(2) The amounts in subsection (1)(b) and (c) of this section may be increased by an amount equal to the employee's weekly benefit amount for medical leave multiplied by two if the employee experiences a serious health condition with a pregnancy that results in incapacity.

(3) An overpayment waived under WAC 192-640-015 shall be charged against the employee's applicable entitlement for the claim year containing the weeks to which the overpayment was attributed as though such benefits had been properly paid.

NEW SECTION

WAC 192-620-030 How do supplemental benefit payments affect employer requirements and weekly benefit payments? (1) Supplemental benefits made by an employer to an employee are excluded from the definition of wages in RCW 50A.05.010.

(2) Employers should not report supplemental benefit payments or associated hours to the department.

(3) Employees should not report hours of paid time off that have been offered as supplemental benefit payments by the employer to the department on the weekly application for benefits.

NEW SECTION

WAC 192-620-035 When will a weekly benefit amount be prorated? For an employee on paid family or medical leave, a weekly benefit amount is prorated when:

(1) The employee works hours for wages; or

(2) The employee uses paid sick leave, paid vacation leave, or other paid time off that is not considered a supplemental benefit payment as defined in WAC 192-500-180.

Example 1: An employee has already served a waiting period in the claim year and files a claim for a week of paid medical leave. The employee typically works forty hours a week at eight hours per day. In the week for which the employee is claiming, the employee claimed one day of paid medical leave and worked the other four days. This employee's weekly benefit is usually $800. The weekly benefit would then be prorated by the hours on paid medical leave (eight hours) relative to the typical workweek hours (40 hours). Eight hours is 20% of 40 hours. The employee's weekly benefit would be prorated to 20% for a total of $160.

Example 2: An employee files a claim for eight hours of paid family and medical leave and takes sick leave from the employer for the same day. The employer does not offer the sick leave as a supplemental benefit payment. The sick leave is considered hours worked by the employee. The employee is being paid for the same hours claimed on paid family and medical leave. This employee is not eligible for benefits for this week.

NEW SECTION

WAC 192-620-040 How will the department determine the number of hours of paid family or medical leave an employee claims each week? (1) When the employee submits a weekly application for benefits as described in WAC 192-620-020, the department will determine the number of hours claimed by the employee for that week by determining the typical workweek hours as described in WAC 192-610-050, then deducting the number of hours:

(a) Physically worked by the employee; and

(b) Claimed by the employee as sick leave, vacation leave, or other paid time off that has not been offered as a supplemental benefit by the employer.

(2) The result of the calculation in subsection (1) of this section will be deducted from the employee's duration of paid family and medical leave for the current claim year and, if necessary, for the purposes of proration as described in WAC 192-620-035.

NEW SECTION

WAC 192-620-045 How will the department reduce a payment if the employee owes child support? (1) After being properly notified by a child support agency, the department will withhold a portion of an employee's benefit payment to send to the agency to satisfy child support obligations.

(2) The child support agency is responsible for notifying the employee of the order to deduct child support from paid family or medical leave benefits.

(3) Benefits deducted to satisfy child support obligations are considered paid to the employee. If an employee receives benefits to which the employee is not entitled, the amount deducted to satisfy child support obligations will be included in the overpayment.

(4) The child support agency is responsible for reimbursing the employee if the amount deducted from the employee's benefits is greater than the employee is required to pay to satisfy the employee's child support obligations. If an amount less than the employee is required to pay is deducted from the employee's benefits, the department will deduct the additional amount from future benefit weeks.

NEW SECTION

WAC 192-620-046 How can an employee appeal a deduction from weekly benefit payments to satisfy child support obligations? (1) The employee must file an appeal concerning the validity of the child support order, the total amount due, or the amount to be deducted from the employee's benefits, with the child support agency.

(2) The employee may file an appeal concerning the department's authority to deduct child support from paid family or medical leave benefits, the weeks for which the deduction is made, and the accuracy of the amount deducted with the department in the same manner as eligibility decisions are appealed. All laws and rules pertaining to benefit appeals apply to appeals under this subsection.

Chapter 192-800 WAC

((~~PRACTICE~~)) APPEALS AND PROCEDURE

NEW SECTION

WAC 192-800-025 Adoption of model rules. The model rules of procedure contained in chapter 10-08 WAC, are, to the extent they are not inconsistent with the rules contained in this chapter, adopted as the rules of procedure for Title 50A RCW. The rules contained in this title will, to the extent of any conflict with the model rules of procedure, be deemed to supersede the conflicting provisions of the model rules of procedure.

NEW SECTION

WAC 192-800-030 Definitions. Unless context clearly indicates otherwise, the following terms and phrases shall have these meanings for this chapter:

(1) "Appeal" means a request for a hearing before and decision by the office of administrative hearings in a matter involving paid family or medical leave premiums or penalty assessments or any determinations under Title 50A RCW.

(2) "Petition for review" means a request directed to the commissioner for a review of the proceedings held and decision issued by the office of administrative hearings.

(3) "Commissioner" means the commissioner's review office of the employment security department.

NEW SECTION

WAC 192-800-035 Who can appeal or submit a petition for review? (1) An aggrieved person as defined in WAC 192-500-040 may file an appeal to the department by using the department's online services, or in another format approved by the department.

(2) Any aggrieved person who receives a decision from the office of administrative hearings, other than an order approving a withdrawal of appeal, a consent order, or an interim order, may file a written petition for review, including filing by using the department's online services, or in another format approved by the department.

NEW SECTION

WAC 192-800-040 What are the timeliness requirements for submitting an appeal or a petition for review? (1) An appeal or a petition for review from a determination, redetermination, order and notice of assessment of premiums or penalties, appeals decision, or commissioner's decision is deemed filed and received if the provisions within RCW 50A.50.040 are met.

(2) An appeal must be filed within thirty days of the date the notification or mailing, whichever is the earlier. The appeal must be filed in accordance with the provisions of RCW 50A.50.010.

(3) The petition for review must be filed within thirty days of the date of delivery or mailing of the decision of the office of administrative hearings, whichever is the earlier.

The petition for review must be filed in accordance with the provisions of RCW 50A.50.080.

(4) The following factors shall be considered in determining whether good cause exists under RCW 50A.50.120 for the late filing of an appeal or a petition for review:

(a) The length of the delay;

(b) The excusability of the delay; and

(c) Whether acceptance of the late filed appeal or petition for review will result in prejudice to other interested parties, including the department.

(5) In determining the excusability for the late filing of an appeal or petition for review, the office of administrative hearings or the commissioner's review office will consider:

(a) Whether any physical, mental, educational or linguistic limitations of the appealing or petitioning party exist, including any lack of facility with the English language; and

(b) The length of the delay in filing. Untimely appeals filed after the filing deadline require a more compelling reason commensurate with the length of the delay.

NEW SECTION

WAC 192-800-045 When can an appeal be withdrawn? An aggrieved person may withdraw their appeal or petition for review upon approval by the office of administrative hearings or the commissioner's review office, respectively, at any time prior to the decision, in which case the determination, redetermination, order and notice of assessment of premiums or penalties, or other decision appealed, shall be final in accordance with the provisions of Title 50A RCW.

NEW SECTION

WAC 192-800-050 What happens after an appeal is submitted? Upon receipt of a notice of appeal, the commissioner shall request the assignment of an administrative law judge under chapter 34.12 RCW to conduct a hearing in accordance with chapter 34.05 RCW and issue an initial order.

NEW SECTION

WAC 192-800-055 Who will be notified if an appeal is filed and what will it include? (1) All interested parties to an appeal will be notified when an appeal has been filed.

(2) The notice will contain information related to the determination or redetermination being appealed.

NEW SECTION

WAC 192-800-060 What happens if an appeal or a petition has been filed and one of the parties has a change of contact information? (1) Once an appeal has been filed, any interested party must notify the office of administrative hearings of any change of contact information.

(2) Once a petition for review has been filed, any interested party must notify the commissioner's review office of any change of contact information.

(3) Any interested party who fails to comply with this section will not have good cause for failure to appear at a hearing or for late filing of a petition for review or untimely submission of a reply or petition for reconsideration.

NEW SECTION

WAC 192-800-065 How does the time computation work for perfecting an appeal or petition for review? The time within which an appeal or a petition for review is to be perfected under Title 50A RCW is computed by excluding the day of delivery or mailing of the determination or redetermination, and by including the last day. If the last day is a Saturday or Sunday or a holiday, as defined in RCW 1.16.050, the appeal or petition for review must be perfected no later than the next business day.

NEW SECTION

WAC 192-800-070 Who can give testimony and examine witnesses during an appeal hearing? In an appeal hearing, any interested party, or legally authorized representative of an interested party, has the right to give testimony and to examine and cross-examine any other interested party or witnesses with respect to facts material and relevant to the issues involved.

NEW SECTION

WAC 192-800-075 Who can request a postponement of a hearing? (1) Any party to a hearing may request a postponement of a hearing at any time prior to the actual convening of the hearing. The granting or denial of the request will be at the discretion of the presiding administrative law judge.

(2) The presiding administrative law judge may in the exercise of sound discretion grant a continuance of a hearing at any time at the request of any interested party or on the judge's own motion.

NEW SECTION

WAC 192-800-080 Will depositions and written discovery be permitted? The presiding administrative law judge has the discretion to allow taking of depositions and submission of interrogatories or requests for production either on the judge's own motion or at the request of any interested party.

NEW SECTION

WAC 192-800-085 When will administrative law judges hear consolidated cases? The presiding administrative law judge may hear individual matters on a consolidated record if there is a substantial identity of issues and the rights of no interested party will be adversely affected. This procedure should provide for the hearing of additional or unique issues relating to individual cases.

NEW SECTION

WAC 192-800-090 What is included in decisions issued by the office of administrative hearings? Every decision issued by the office of administrative hearings, other

than an order approving a withdrawal of appeal, a consent order, or an interim order, and every decision issued by the commissioner under RCW 50A.50.090, other than an interim order or an order granting or denying a motion for reconsideration or a stay, shall:

(1) Be captioned and include the name of the agency and name of the proceeding;

(2) Designate all parties and representatives participating in the proceeding;

(3) Include a concise statement of the nature and background of the proceeding;

(4) Contain appropriate numbered findings of fact meeting the requirements in RCW 34.05.461;

(5) Contain appropriate numbered conclusions of law, including citations of statutes and rules relied upon;

(6) Contain an initial or final order disposing of all contested issues; and

(7) Be accompanied by or contain a statement of petition for review or petition for judicial review rights.

NEW SECTION

WAC 192-800-095 Can a decision of the commissioner incorporate a decision under review? A decision of the commissioner issued under RCW 50A.50.090 may incorporate by reference any portion of the decision under review. Such incorporation satisfies the requirements of WAC 192-800-090.

NEW SECTION

WAC 192-800-100 What is the process for filing petition for review and any reply to the petition for review? (1) The written petition for review must be filed by using the department's online services or by mailing it to the Commissioner's Review Office, Employment Security Department, Post Office Box 9555, Olympia, WA 98507-9555, within thirty days of the date of mailing or delivery of the decision of the office of administrative hearings, whichever is earlier.

(2) Any written argument in support of the petition for review must be attached to the petition for review and be filed at the same time. The commissioner's review office will acknowledge receipt of the petition for review by assigning a review number to the case, entering the review number on the face of the petition for review, and setting forth the acknowledgment date on the petition for review. The commissioner's review office will also send copies of the acknowledged petition for review and attached argument in support thereof to the petitioning party, nonpetitioning party, and their representatives of record, if any.

(3) Any reply to the petition for review and any argument in support thereof by the nonpetitioning party must be filed by using the department's online services or by mailing it to the Commissioner's Review Office, Employment Security Department, Post Office Box 9555, Olympia, WA 98507-9555. The reply must be received by the commissioner's review office within fifteen days of the date of the acknowledged petition for review. An informational copy must be mailed by the nonpetitioning party to all other parties of record and their representatives, if any.

(4) The petition for review and argument in support thereof, and the reply to the petition for review and argument in support thereof, must:

(a) Be captioned, and include the docket number of the decision of the office of administrative hearings, and be signed by the party submitting it or by a designated representative of that party; and

(b) Be legible, reproducible, and five pages or less.

(5) Arrangements for representation and requests for copies of the hearing record and exhibits will not extend the period for the filing of a petition for review, argument in support thereof, or a reply to the petition for review.

(6) Any argument in support of the petition for review or in reply thereto not submitted in accordance with the provisions of this regulation is not considered in the disposition of the case unless it is determined that the failure to comply with these provisions was beyond the reasonable control of the individual seeking relief.

NEW SECTION

WAC 192-800-105 When and how can an administrative law judge dispose of an appeal? (1) The presiding administrative law judge may dispose of any appeal through:

(a) An order approving a withdrawal of appeal;

(b) A consent order; or

(c) An order of default.

(2) There will be no petition for review rights from an order approving a withdrawal of appeal or a consent order.

NEW SECTION

WAC 192-800-110 What options are available for an aggrieved person who received an order of default? (1) Any person aggrieved by the entry of an order of default may:

(a) File a motion to vacate the order of default with the office of administrative hearings within seven days of issuance of the order; or

(b) File a petition for review from such order by complying with the filing requirements set forth in WAC 192-800-100.

(2) The provisions in subsection (1)(a) of this section toll the appeal period for filing a timely petition for review with the commissioner's review office until the office of administrative hearings issues a ruling on the motion. However, should a petition for review be filed while a ruling on a motion to vacate is pending, the office of administrative hearings no longer has jurisdiction to vacate the default order.

(3) Under subsection (1)(b) of this section, an order of default will be set aside by the commissioner's review office only upon a showing of good cause for failure to appear or to request a postponement prior to the scheduled time for hearing. In the event such an order of default is set aside, the commissioner will remand the matter to the office of administrative hearings for hearing and decision.

NEW SECTION

WAC 192-800-115 What is the process for filing a petition for reconsideration to the commissioner's review office? (1) A written petition for reconsideration and argu-

ment in support thereof must be filed within ten days of the date of the decision of the commissioner. It must be filed by using the department's online services or by mailing it to the Employment Security Department, Post Office Box 9555, Olympia, WA 98507-9555.

(2) The petitioner must provide the petition for reconsideration in subsection (1) of this section to all interested parties.

(3) No matter will be reconsidered by the commissioner unless it clearly appears from the face of the petition for reconsideration and the argument submitted in support thereof that:

(a) There is obvious material, clerical error in the decision; or

(b) The petitioner, through no fault of the petitioner, was denied a reasonable opportunity to present argument or respond to argument under WAC 192-800-100.

(4) A petition for reconsideration is deemed to have been denied if, within twenty days from the date the petition for reconsideration is filed, the commissioner does not either:

(a) Dispose of the petition for reconsideration; or

(b) Mail or deliver to the parties a written notice specifying the date by which the parties will act on the petition for reconsideration. If no action is taken by the date specified in such written notice, the petition will be deemed to have been denied.

(5) A petition for reconsideration does not stay the effectiveness of the decision of the commissioner. The filing of a petition for reconsideration is not a prerequisite for filing a petition for judicial review. An order denying reconsideration or a written notice specifying the date upon which action will be taken on the petition for reconsideration is not subject to judicial review.

NEW SECTION

WAC 192-800-120 When would the commissioner not issue declaratory orders. The commissioner will not issue a declaratory order on any matter that may be adjudicated under any statute, regulation, or other provision of law. No declaratory order will be issued that is merely an advisory opinion.

NEW SECTION

WAC 192-800-125 When is a petition for review considered delivered to the department? Delivery under RCW 34.05.542(4) is made when a copy of the petition for judicial review is received by the Commissioner's Office at 212 Maple Park Avenue S.E., Olympia, WA or received by mail at the Commissioner's Review Office, Post Office Box 9555, Olympia, WA 98507-9555.

NEW SECTION

WAC 192-800-150 Can an employee designate a representative to act on their behalf? (1) The department may authorize another individual to act on the employee's behalf for the purposes of paid family and medical leave benefits if:

(a) An employee designates an authorized representative by submitting written documentation as required by the department;

(b) A court-appointed legal guardian with authority to make decisions on a person's behalf submits documentation as required by the department;

(c) An individual designated as a power of attorney submits documentation satisfactory to the department to act on the employee's behalf; or

(d) If an employee is unable to designate an authorized representative due to a serious health condition, an individual may represent the employee by submitting a complete and signed authorized representative designation form made available by the department, which must include:

(i) Documentation from the employee's health care provider certifying that the employee is incapable of completing the administrative requirements necessary for receiving paid family and medical leave benefits and is unable to designate an authorized representative to act on the employee's behalf; and

(ii) An affidavit or declaration authorized by RCW 9A.72.085 attesting to the responsibility to act in the employee's best interest.

(2) The department will terminate the authority given to the authorized representative:

(a) When the employee or authorized representative notifies the department verbally or in writing; or

(b) At the department's discretion.

(3) For the purposes of paid family and medical leave the term employee is used for both employee and authorized representative.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 192-800-002 Untimely appeals.

WAC 192-800-003 Designating an authorized representative.