WSR 20-13-009
PROPOSED RULES
DEPARTMENT OF
SOCIAL AND HEALTH SERVICES
(Economic Services Administration)
[Filed June 5, 2020, 10:49 a.m.]

June 4, 2020
Katherine I. Vasquez
Rules Coordinator

Original Notice.

Preproposal statement of inquiry was filed as WSR 20-08-111.

Title of Rule and Other Identifying Information: The department is proposing amendments to WAC 388-310-1300 Community jobs.

Hearing Location(s): On July 21, 2020, at 10:00 a.m., at Office Building 2, Department of Social and Health Services (DSHS) Headquarters, 1115 Washington Street S.E., Olympia, WA 98504. Public parking at 11th and Jefferson. A map is available at https://www.dshs.wa.gov/office-of-the-secretary/driving-directions-office-bldg-2; or by Skype. Due to the COVID-19 pandemic, hearing may be held via Skype, see DSHS website for most up to date information.

Date of Intended Adoption: Not earlier than July 22, 2020.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504, email DSHSRPAU RulesCoordinator@dshs.wa.gov, fax 360-664-6185, by 5:00 p.m., July 21, 2020.

Assistance for Persons with Disabilities: Contact Jeff Kildahl, DSHS rules consultant, phone 360-664-6092, fax 360-664-6185, TTY 711 relay service, email Kildaja@dshs.wa.gov, by July 7, 2020.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Proposed amendments to WAC 388-310-1300 will strike inoperative rule language related to unemployment compensation, as eligibility for unemployment compensation is determined by the employment security department.

Reasons Supporting Proposal: Proposed amendments to WAC 388-310-1300 will better align the rule with statutory authority.

Statutory Authority for Adoption: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 74.08A.320.

Statute Being Implemented: None.

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

Name of Proponent: DSHS, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: Jake Deskins, P.O. Box 45470, Olympia, WA 98504-5770, 360-725-4639.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. This amendment is exempt as allowed under RCW 34.05.328 (5)(b)(vii) which states in part, "[t]his section does not apply to … rules of the department of social and health services relating only to client medical or financial eligibility and rules concerning liability for care of dependents.["]

Is exempt under RCW 34.05.328 (5)(b)(vii).

Explanation of exemptions: These amendments do not impact small business. They only impact DSHS clients.

AMENDATORY SECTION (Amending WSR 15-24-057, filed 11/24/15, effective 1/1/16)

WAC 388-310-1300 Community jobs. (1) **What is the community jobs program?**

Community jobs is a paid work experience that assists you to gain work skills and experience. You are placed in a community job (up to twenty hours per week) where your wages are paid by the community jobs program. If you participate in the program, you are eligible for support services that assist you in moving into a job where your employer pays all your wages.

(2) **What is career jump?**

Career jump offers job-ready community jobs participants an opportunity to gain paid work experience that leads to a permanent job. This program is a subset of community jobs and will be referred to as such. Career jump places you in a part time (up to twenty hours per week), community job where your earnings are paid by the community jobs program, for up to five months, at which time you will transition to the employer's payroll. You will be provided with support services to assist you in retaining your job through the ninth month of the program. At or before the fifth month, the employment opportunity will be above minimum wage, thirty-two or more hours per week and include wage progression and benefits comparable to other employees.

(3) **Who administers the community jobs program?**

The department of commerce (commerce) administers the community jobs program. Commerce contracts with local agencies throughout the state, known as community jobs contractors who develop and manage the community jobs positions, pay the wages, provide support services and act as the "employer of record" while you are enrolled in a community job.

(4) **What types of work sites are used to provide community jobs?**

The following work sites may be used to provide community jobs:

(a) Federal, state or local governmental agencies and tribal governments;

(b) Private and tribal nonprofit businesses, organizations and educational institutions;

(c) Private for profit businesses for career jump placements.

(5) **What are the requirements for the work sites?**

Work sites for community jobs and career jump:

(a) Must assist in strengthening work ethics, improve workplace skills and help you gain skills to move into a job where the employer pays all your wages. If they do not meet this requirement, they will not be considered for additional community jobs/career jump placements.

(b) We will follow the employment rules described in WAC 388-310-1500. In any situation where training is inconsistent with the terms of a collective bargaining agreement, your community jobs contractor will obtain written approval from the labor organization concerned. Career jump employ-

ers will remain neutral with regard to neutralization in the worksite.

(c) You will not be required to do work related to religious, electoral or partisan political activities.

(6) **What are the benefits of community jobs?**

You benefit from community jobs by:

(a) Learning work skills;

(b) Getting work experience;

(c) Working twenty hours per week, while being paid federal, state, or local minimum wage, whichever is higher; and

(d) Earning paid personal leave as determined by commerce.

(7) **How do I get into community jobs?**

You will be placed into community jobs after you and your DSHS case manager decide:

(a) You would benefit from community jobs after you have participated in job search without finding a job; and/or

(b) You need a supportive work environment to help you become more employable.

(8) **What happens after I am placed in the community jobs program?**

When you are placed in the community jobs program by DSHS:

(a) You will be assigned to a community job by the community jobs contractor for no more than nine months. You will work twenty hours a week and participate in any other unpaid activities as required in your individual responsibility plan for:

(i) Three additional hours per week when you are a single parent or caretaker relative with a child under six.

(ii) Twelve to twenty additional hours per week when you do not meet the criteria in (8)(a)(i).

(b) Your placement in community jobs will be reviewed by your DSHS case manager every three months during your nine-month placement for the following:

(i) To ensure you are TANF/SFA eligible; and

(ii) To verify any earned or unearned income received by you or another member of your assistance unit (that is, you and other people in your household who are included on your cash grant).

(c) Your community jobs contractor will review your case each month to ensure you are following your IRP and IDP, participating full time, and becoming more employable because of your community job;

(d) If you request a different community jobs placement, we do not consider your request a refusal to participate without good cause under WAC 388-310-1600. You may be asked to explain why you want a different placement;

(e) Grievance policies are in place for your protection. You will be required to sign an acknowledgment that you received a copy of this policy at the time of placement with the employer.

(9) **How does community jobs affect my TANF benefits?**

The amount of your TANF/SFA monthly grant will be determined by following the rules in WAC 388-450-0050 and 388-450-0215 (1), (3), (4), (5) and (6). WAC 388-450-0215(2), does not apply to your community jobs wages.

(10) **What can I expect from my career jump placement?**

(a) You cannot represent more than ten percent of the total labor force for an employer that has ten or more employees.

(b) No more than one community jobs participant shall be allowed per private for profit worksite supervisor.

(c) You will participate in developing a career progression plan that will include health care benefits comparable to other employees.

(d) ((~~You may be eligible for unemployment benefits if you have participated in community jobs' career jump and have worked at least six hundred eighty hours in a base year. You will gain unemployment insurance credits for all hours worked under your career jump placement.~~

~~(e)~~)) Your employer and your community jobs contractor will be required to follow commerce's contractual agreements for career jump.

WSR 20-13-014
PROPOSED RULES
UTILITIES AND TRANSPORTATION COMMISSION

[Filed June 5, 2020, 3:25 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 19-21-016.

Title of Rule and Other Identifying Information: Chapter 480-109 WAC, Electric companies—Acquisition of minimum quantities of conservation and renewable energy as required by the Energy Independence Act. This rule making, filed in Docket UE-190652, will address changes to chapter 480-109 WAC. These changes include amendments to clarify or streamline the rules, incorporate changes to the Energy Independence Act (EIA) found in chapter 288, Laws of 2019, which were passed as E2SSB 5116 (portions of which are now codified in chapter 19.405 RCW), and changes from chapter 315, Laws of 2017, which were found in ESB 5128.

Hearing Location(s): On July 28, 2020, at 9:30 a.m.

Via Skype: (360) 407-3810, conference ID 28778362; or LINK: https://lync.wa.gov/utc.wa.gov/meet/aldcalendar/SCBP2T4B. Public hearing to consider adoption of the proposed rules.

Date of Intended Adoption: July 28, 2020.

Submit Written Comments to: Executive Director and Secretary, P.O. Box 47250, Olympia, WA, 98504-7250, email records@utc.wa.gov, by July 6, 2020.

Assistance for Persons with Disabilities: Contact Susan Holman, phone 360-664-1243, TTY 360-586-8203, email susan.holman@utc.wa.gov, by July 14, 2020.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposed rules implement legislative changes made in 2017 and 2019 and streamline implementation of chapter 19.285 RCW. The proposed amendments modify or add definitions, incorporate language pertaining to energy assistance, change the manner in which utility low-income programs operate, amend the

renewable portfolio standard compliance and reporting rules, and amend the energy and emission intensity reporting rules.

Reasons Supporting Proposal: The Washington legislature in 2019 passed the Clean Energy Transformation Act, which included among its provisions several amendments to the EIA. The primary reason for this rule making is to codify these amendments in the current EIA rules in chapter 480-109 WAC. The rule making will also codify changes made in the 2017 legislative session through ESB 5128. Finally, the rule making will make a number of other amendments that help streamline the implementation of the EIA.

Statutory Authority for Adoption: RCW 80.01.040, 80.04.160, 19.285.080, and 19.405.100.

Statute Being Implemented: RCW 19.405.020, 19.405.-070, 19.405.120, 19.285.030, and 19.285.040.

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

Name of Proponent: Washington utilities and transportation commission (UTC), governmental.

Name of Agency Personnel Responsible for Drafting: Andrew Rector, 621 Woodland Square Loop S.E., Lacey, WA 98503, 360-664-1315; Implementation and Enforcement: Mark L. Johnson, 621 Woodland Square Loop S.E., Lacey, WA 98503, 360-664-1115.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. UTC is not an agency to which RCW 34.05.328 applies.

The proposed rule does not impose more-than-minor costs on businesses. Following is a summary of the agency's analysis showing how costs were calculated. The proposed rule amendments apply to Washington's electric investor-owned utilities, and they are not considered small businesses under RCW 19.85[.025](3). A small business economic impact statement questionnaire for this rule making was released on January 16, 2020. It received no responses.

June 5, 2020
Mark L. Johnson
Executive Director and Secretary

AMENDATORY SECTION (Amending WSR 15-07-043, filed 3/12/15, effective 4/12/15)

WAC 480-109-060 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Annual retail revenue requirement" means the total revenue the commission authorizes a utility an opportunity to recover in Washington rates pursuant to a general rate proceeding or other general rate revision.

(2) "Biomass energy" means:

(a) The electrical energy produced by a generation facility powered by:

(i) Organic by-products of pulping and the wood manufacturing process;

(ii) Animal manure;

(iii) Solid organic fuels from wood;

(iv) Forest or field residues;

(v) Untreated wooden demolition or construction debris;

(vi) Food waste and food processing residuals;

(vii) Liquors derived from algae;

(viii) Dedicated energy crops; and

(ix) Yard waste.

(b) Biomass energy does not include:

(i) Wood pieces that have been treated with chemical preservatives such as creosote, pentachlorophenol, or copper-chrome arsenic;

(ii) Wood from old growth forests; or

(iii) Municipal solid waste.

(3) "Carbon dioxide equivalents" or "CO_2e" has the same meaning as in RCW 70.235.010.

(4) "Certificate" means proof of ownership, registered in WREGIS, of the nonpower attributes associated with a megawatt-hour of generation from an eligible renewable resource.

(((~~(4)~~))) (5) "Coal transition power" means the output of a coal-fired electric generation facility that is subject to an obligation to meet the standards contained in RCW 80.80.040 (3)(c).

(((~~(5)~~))) (6) "Commission" means the Washington utilities and transportation commission.

(((~~(6)~~))) (7) "Conservation" means any reduction in electric power consumption resulting from increases in the efficiency of energy use, production, or distribution.

(((~~(7)~~))) (8) "Cost-effective" means, consistent with RCW 80.52.030, that a project or resource is forecast:

(a) To be reliable and available within the time it is needed; and

(b) To meet or reduce the electric power demand of the intended consumers at an estimated incremental system cost no greater than that of the least-cost similarly reliable and available alternative project or resource, or any combination thereof.

(((~~(8) "Council" means the Northwest Power and Conservation Council.~~)))

(9) "Customer" means a person or entity that purchases electricity for ultimate consumption and not for resale.

(10) "Department" means the department of commerce or its successor.

(11) "Distributed generation" means an eligible renewable resource where the generation facility or any integrated cluster of such facilities has a nameplate capacity of not more than five megawatts alternating current. An integrated cluster is a grouping of generating facilities located on the same or contiguous property having any of the following elements in common: Ownership, operational control, or point of common coupling.

(12) "Eligible renewable resource" means:

(a) Electricity from a generation facility powered by a renewable resource other than fresh water that commences operation after March 31, 1999, where:

(i) The facility is located in the Pacific Northwest; or

(ii) The electricity from the facility is delivered into Washington state on a real-time basis without shaping, storage, or integration services.

(b) Incremental electricity produced as a result of efficiency improvements completed after March 31, 1999, to hydroelectric generation projects owned by a qualifying utility and located in the Pacific Northwest, where the additional

generation does not result in new water diversions or impoundments;

(c) Hydroelectric generation from a project completed after March 31, 1999, where the generation facility is located in irrigation pipes, irrigation canals, water pipes whose primary purpose is for conveyance of water for municipal use, and wastewater pipes located in Washington, where the generation does not result in new water diversion or impoundments;

(d) Qualified biomass energy; ((~~or~~))

(e) For a qualifying utility that serves customers in other states, electricity from a generation facility powered by a renewable resource other than freshwater that commenced operation after March 31, 1999, where:

(i) The facility is located within a state in which the qualifying utility serves retail electrical customers; and

(ii) The qualifying utility owns the facility in whole or in part or has a long-term contract with the facility of at least twelve months.

(((~~(13)~~))) (f)(i) Incremental electricity produced as a result of a capital investment completed after January 1, 2010, that increases, relative to a baseline level of generation prior to the capital investment, the amount of electricity generated in a facility that generates qualified biomass energy as defined under subsection (29)(c)(ii) of this section and that commenced operation before March 31, 1999;

(ii) Beginning January 1, 2007, the facility must demonstrate its baseline level of generation over a three-year period prior to the capital investment in order to calculate the amount of incremental electricity produced;

(iii) The facility must demonstrate that the incremental electricity resulted from the capital investment, which does not include expenditures on operation and maintenance in the normal course of business, through direct or calculated measurement.

(g) That portion of incremental electricity produced as a result of efficiency improvements completed after March 31, 1999, attributable to a qualifying utility's share of the electricity output from hydroelectric generation projects whose energy output is marketed by the Bonneville Power Administration where the additional generation does not result in new water diversions or impoundments; or

(h) The environmental attributes, including renewable energy credits, from (g) of this subsection transferred to investor-owned utilities pursuant to the Bonneville Power Administration's residential exchange program.

(13) "Energy assistance" means a program undertaken by a utility to reduce the household energy burden of its customers.

(a) Energy assistance includes, but is not limited to, weatherization, conservation and efficiency services, and monetary assistance, such as a grant program or discounts for lower income households, intended to lower a household's energy burden.

(b) Energy assistance may include direct customer ownership in distributed energy resources or other strategies if such strategies achieve a reduction in energy burden for the customer above other available conservation and demand-side measures.

(14) "Energy assistance need" means the amount of assistance necessary to achieve an energy burden equal to six percent for utility customers.

(15) "Energy burden" means the share of annual household income used to pay annual home energy bills.

(16) "Greenhouse gas," "greenhouse gases," "GHG," and "GHGs" includes carbon dioxide, methane, nitrous oxide, hydrofluorocarbons, perfluorocarbons, sulfur hexafluoride, and any other gas or gases designated by the department of ecology in WAC 173-441-040 or its successor, should that provision be amended or recodified.

(17) "Greenhouse gas content calculation" means a calculation expressed in carbon dioxide equivalents made by the department of ecology for the purposes of determining the emissions from the complete combustion or oxidation of fossil fuels and the greenhouse gas emissions in electricity for use in calculating the greenhouse gas emissions content in electricity.

(18) "High-efficiency cogeneration" means the sequential production of electricity and useful thermal energy from a common fuel source resulting in a reduction in customer load where under normal operating conditions the useful thermal energy output is no less than thirty-three percent of the total energy output. The reduction in customer load is determined by multiplying the annual electricity output of the cogeneration facility by a fraction equal to one minus the ratio of:

(a) The heat rate (in British thermal units per megawatt hour) of the cogeneration facility based on the additional fuel requirements attributable to electricity production and excluding the fuel that would be required to produce all other useful energy outputs of the project without cogeneration, divided by the heat rate (in British thermal units per megawatt hour) of a combined cycle natural gas-fired combustion turbine. The heat rate of the combustion turbine must be based on a facility using best commercially available technology on a new and clean basis.

(b) Calculation of the reduction in customer load is made with the following formula:

$$\text{Megawatt-hours reductions in customer load} = \left(\begin{array}{c}\text{Annual}\\ \text{megawatt- hours}\\ \text{of cogen. elect.}\end{array}\right) \times \left[1 - \left(\frac{\text{heat rate based on fuel used for electric portion of cogen.}}{\begin{array}{c}\text{heat rate for a new clean natural gas fired combined cycle}\\ \text{combustion turbine using best available commercial technology}\end{array}}\right)\right]$$

(((~~(14)~~))) (19) "Incremental cost" means the difference between the levelized delivered cost of an eligible renewable resource, regardless of ownership, compared to the levelized delivered cost of an equivalent amount of reasonably available substitute resources that do not qualify as eligible renewable resources, where the resources being compared have the same contract length or facility life.

(((~~(15)~~))) (20) "Integrated resource plan" or "IRP" means the filing made ((~~every two years~~)) by an electric utility in accordance with WAC 480-100-238((~~, integrated resource planning~~)).

(((~~(16)~~))) (21) "Load" means the amount of kilowatt-hours of electricity delivered in the most recently completed year by a qualifying utility to its Washington retail customers. Load does not include off-system sales or electricity delivered to transmission-only customers.

(((~~(17)~~))) (22) "Low-income" means household incomes that do not exceed the higher of eighty percent of area median income or two hundred percent of federal poverty level, adjusted for household size.

(23)(a) "Nonemitting electric generation" means electricity from a generating facility or a resource that provides electric energy, capacity, or ancillary services to an electric utility and that does not emit greenhouse gases as a by-product of energy generation.

(b) "Nonemitting electric generation" does not include renewable resources.

(24)(a) "Nonpower attributes" means all environmentally related characteristics, exclusive of energy, capacity reliability, and other electrical power service attributes, that are associated with the generation of electricity from a renewable resource including, but not limited to, the facility's fuel type, geographic location, vintage, qualification as an eligible renewable resource, and avoided emissions of pollutants to the air, soil, or water, and avoided emissions of carbon dioxide and other greenhouse gases.

(b) "Nonpower attributes" does not include any aspects, claims, characteristics, and benefits associated with the onsite capture and destruction of methane or other greenhouse gases at a facility through a digester system, landfill gas collection system, or other mechanism, which may be separately marketable as greenhouse gas emission reduction credits, offsets, or similar tradable commodities. However, these separate avoided emissions may not result in or otherwise have the effect of attributing greenhouse gas emissions to the electricity.

(((~~(18)~~))) (25) "Pacific Northwest" has the same meaning as defined for the Bonneville Power Administration in section 3 of the Pacific Northwest Electric Power Planning and Conservation Act (94 Stat. 2698; 16 U.S.C. Sec. 839a).

(((~~(19)~~))) (26) "Pro rata" means the calculation dividing the utility's projected ten-year conservation potential into five equal proportions to establish the minimum biennial conservation target.

(((~~(20)~~))) (27) "Production efficiency" means investments and actions that save electric energy from power consuming equipment and fixtures at an electric generating facility. The installation of electric power production equipment that increases the amount of power generated for the same energy input is not production efficiency in this chapter or conservation under RCW 19.285.030(4) because no reduction in electric power consumption occurs.

(((~~(21)~~))) (28) "Pursue all" means an ongoing process of researching and evaluating the range of possible conservation technologies and programs, and implementing all programs which are cost-effective, reliable and feasible.

(((~~(22)~~))) (29) "Qualified biomass energy" means electricity produced from a biomass energy facility that:

(a) Commenced operation before March 31, 1999;

(b) Contributes to the qualifying utility's load; and

(c) Is owned either by:

(i) A qualifying utility; or

(ii) An industrial facility that is directly interconnected with electricity facilities that are owned by a qualifying utility and capable of carrying electricity at transmission voltage.

(((~~(23)~~))) (30) "Regional technical forum" means the advisory committee established by the Northwest Power and Conservation Council.

(((~~(24)~~))) (31) "Renewable energy credit" means a tradable certificate of proof of ((~~at least~~)) one megawatt-hour of an eligible renewable resource ((~~where the generation facility is not powered by fresh water,~~)). The certificate includes all of the nonpower attributes associated with that one megawatt-hour of electricity((~~,~~)) and the certificate is verified by a renewable energy credit tracking system selected by the department.

(((~~(25)~~))) (32) "Renewable resource" means:

(a) Water;

(b) Wind;

(c) Solar energy;

(d) Geothermal energy;

(e) Landfill gas;

(f) Wave, ocean, or tidal power;

(g) Gas from sewage treatment facilities;

(h) Biodiesel fuel ((~~as defined in RCW 82.29A.135~~)) that is not derived from crops raised on land cleared from old growth or first-growth forests where the clearing occurred after December 7, 2006;

(i) Generation facilities in which fossil and combustible renewable resources are cofired in one generating unit that is located in the Pacific Northwest and in which the cofiring commenced after March 31, 1999. These facilities produce eligible renewable resources in direct proportion to the percentage of the total heat value represented by the heat value of the renewable resources; or

(j) Biomass energy, where the eligible renewable energy produced by biomass facilities is based on the portion of the fuel supply that is made up of eligible biomass fuels.

(((~~(26)~~))) (33) "Request for proposal" or "RFP" means the documents describing an electric utility's solicitation of bids for delivering electric capacity, energy, capacity and energy, or conservation.

(((~~(27)~~))) (34) "River discharge" means the total volume of water passing through, over and around all structural components of a hydroelectric facility over a given time.

(((~~(28)~~))) (35) "Single large facility conservation savings" means cost-effective conservation savings achieved in a single biennial period at the premises of a single customer of a utility whose recent annual electricity consumption prior to the conservation savings exceeded five average megawatts.

(((~~(29)~~))) (36) "System cost" means, consistent with RCW 80.52.030, an estimate of all direct costs of a project or resource over its effective life including, if applicable, the costs of distribution to the consumer and among other factors, waste disposal costs, end-of-cycle costs, and fuel costs (including projected increases), and such quantifiable environmental costs and benefits as are directly attributable to the project or resource.

(((~~(30)~~))) (37) "Target year" means the twelve-month period commencing January 1st and ending December 31st

used for compliance with the renewable portfolio standard requirement in WAC 480-109-200(1).

(((~~31~~))) (38) "Utility" means an "electrical company" as that term is defined in RCW 80.04.010 that is subject to the commission's jurisdiction under RCW 80.04.010 and chapter 80.28 RCW.

(((~~32~~))) (39) "WREGIS" means the Western Renewable Energy Generation Information System. WREGIS is the renewable energy credit tracking system designated by the department according to RCW 19.285.030(20).

(((~~33~~))) (40) "Year" means the twelve-month period commencing January 1st and ending December 31st.

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency and appear in the Register pursuant to the requirements of RCW 34.08.040.

AMENDATORY SECTION (Amending WSR 15-07-043, filed 3/12/15, effective 4/12/15)

WAC 480-109-100 Energy efficiency resource standard. (1) **Process for pursuing all conservation.**

(a) **Process.** A utility's obligation to pursue all available conservation that is cost-effective, reliable, and feasible includes the following process:

(i) **Identify potential.** Identify the cost-effective, reliable, and feasible potential of possible technologies and conservation measures in the utility's service territory.

(ii) **Develop portfolio.** Develop a conservation portfolio that includes all available, cost-effective, reliable, and feasible conservation. A utility must develop programs to acquire available conservation from all of the types of conservation identified in (b) of this subsection. The portfolio must include all conservation programs and mechanisms identified pursuant to RCW 19.405.120, which pertain to energy assistance and progress toward meeting energy assistance need, including the low-income conservation programs and mechanisms in subsection (10)(b) of this section.

If no cost-effective, reliable and feasible conservation is available from one of the types of conservation, a utility is not obligated to acquire such a resource.

(iii) **Implement programs.** Implement conservation programs identified in the portfolio to the extent the portfolio remains cost-effective, reliable, and feasible. Implementation methods shall not unnecessarily limit the acquisition of all available conservation that is cost-effective, reliable and feasible.

(iv) **Adaptively manage.** Continuously review and update as appropriate the conservation portfolio to adapt to changing market conditions and developing technologies. A utility must research emerging conservation technologies, and assess the potential of such technologies for implementation in its service territory.

(b) **Types.** Types of conservation include, but are not limited to:

(i) End-use efficiency;

(ii) Behavioral programs;

(iii) High-efficiency cogeneration;

(iv) Production efficiency;

(v) Distribution efficiency; and

(vi) Market transformation.

(c) **Pilots.** A utility must implement pilot projects when appropriate and expected to produce cost-effective savings within the current or immediately subsequent biennium, as long as the overall portfolio remains cost-effective.

(2) **Ten-year conservation potential.** By January 1, 2010, and every two years thereafter, a utility must project its cumulative ten-year conservation potential.

(a) This projection must consider all available conservation resources that are cost-effective, reliable, and feasible.

(b) This projection must be derived from the utility's most recent IRP, including any information learned in its subsequent resource acquisition process, or the utility must document the reasons for any differences. When developing this projection, utilities must use methodologies that are consistent with those used in the Northwest Conservation and Electric Power Plan.

(c) The projection must include a list of each measure used in the potential, its unit energy savings value, and the source of that value.

(3) **Biennial conservation target.** Beginning January 2010, and every two years thereafter, a utility must establish a biennial conservation target.

(a) The biennial conservation target must identify, and quantify in megawatt-hours, all available conservation that is cost-effective, reliable, and feasible.

(b) The biennial conservation target must be no lower than a pro rata share of the utility's ten-year conservation potential.

(c) **Excess conservation.** No more than twenty-five percent of any biennial target may be met with excess conservation savings allowed by this subsection. Excess conservation may only be used to mitigate shortfalls in the immediately subsequent two biennia and may not be used to adjust a utility's ten-year conservation potential or biennial target. The presence of excess conservation does not relieve a utility of its obligation to pursue the level of conservation in its biennial target.

(i) Cost-effective conservation achieved in excess of a biennial conservation target may be used to meet up to twenty percent of each of the immediately subsequent two biennial targets.

(ii) A utility may use single large facility conservation savings achieved in excess of its biennial target to meet up to five percent of each of the immediately subsequent two biennial conservation targets.

(iii) Until December 31, 2017, a utility with an industrial facility located in a county with a population between ninety-five thousand and one hundred fifteen thousand that is directly interconnected with electricity facilities that are capable of carrying electricity at transmission voltage, may use cost-effective excess conservation savings from that industrial facility to meet the subsequent two biennial conservation targets. For purposes of this subsection, transmission voltage is one hundred thousand volts or higher.

(4) **Prudence.** A utility retains the responsibility to demonstrate the prudence of all conservation expenditures, consistent with RCW 19.285.050(2).

(5) **Energy savings.** A utility must use unit energy savings values and standard protocols approved by the regional

technical forum, unless a unit energy savings value or standard protocol is:

(a) Based on generally accepted methods, impact evaluation data, or other reliable and relevant data that includes verified savings levels; and

(b) Presented to its advisory group for review. The commission retains discretion to determine an appropriate value or protocol.

(6) **High efficiency cogeneration.** A utility may count as conservation savings a portion of the electricity output of a high efficiency cogeneration facility in its service territory that is owned by a retail electric customer and used by that customer to meet its heat and electricity needs. Heat and electricity output provided to anyone other than the facility owner is not available for consideration in determining conservation savings. High efficiency cogeneration savings must be certified by a professional engineer licensed by the Washington department of licensing.

(7) **Applicable sectors.** A utility must offer a mix of conservation programs to ensure it is serving each customer sector, including programs targeted to the low-income subset of residential customers.

(8) **Cost-effectiveness.** A utility's conservation portfolio must pass a cost-effectiveness test consistent with that used in the Northwest Conservation and Electric Power Plan. A utility must evaluate conservation using cost-effectiveness tests consistent with those used by the Northwest Power and Conservation Council, and as required by the commission, except as provided by subsection (10) of this section.

(9) **Utility incentives.** A utility may propose to the commission positive incentives designed to stimulate the utility to exceed its biennial conservation target as identified in RCW 19.285.060(4). Any proposed utility incentive must be included in the utility's biennial conservation plan.

(10) **Low-income conservation.**

(a) A utility ((~~may~~)) must fully fund low-income conservation measures that are determined by the implementing agency to be cost-effective consistent with either the *Weatherization Manual* maintained by the department or when it is cost-effective to do so using utility-specific avoided costs. For purposes of this subsection, "fully fund" may include the agency leveraging other funding sources, in combination with utility funds, to fund low-income conservation projects. Measures identified through the priority list in the *Weatherization Manual* are considered cost-effective. In addition, a utility may fully fund repairs, administrative costs, and health and safety improvements associated with cost-effective low-income conservation measures.

(b) The utility's biennial conservation plan must include low-income conservation programs and mechanisms identified pursuant to RCW 19.405.120. To the extent practicable, a utility must prioritize energy assistance to low-income households with a higher energy burden.

(c) A utility ((~~may~~)) must exclude low-income conservation from portfolio-level cost-effectiveness calculations. A utility must account for the costs and benefits, including nonenergy impacts, which accrue over the life of each conservation measure.

(((~~(c)~~))) (d) A utility must count savings from low-income conservation toward meeting its biennial conservation target. Savings may be those calculated consistent with the procedures in the *Weatherization Manual*.

AMENDATORY SECTION (Amending WSR 15-07-043, filed 3/12/15, effective 4/12/15)

WAC 480-109-200 Renewable portfolio standard. (1) **Renewable resource target.** Each utility must meet the following annual targets.

(a) By January 1st of each year beginning in 2012 and continuing through 2015, each utility must use sufficient eligible renewable resources, acquire equivalent renewable energy credits, or a combination of both, to supply at least three percent of its two-year average load for the remainder of each target year.

(b) By January 1st of each year beginning in 2016 and continuing through 2019, each utility must use sufficient eligible renewable resources, acquire equivalent renewable energy credits, or a combination of both, to supply at least nine percent of its two-year average load for the remainder of each target year.

(c) By January 1st of each year beginning in 2020 and continuing each year thereafter, each utility must use sufficient eligible renewable resources, acquire equivalent renewable energy credits, or a combination of both, to supply at least fifteen percent of its two-year average load for the remainder of each target year.

(2) **Credit eligibility.** ((~~Renewable energy credits produced during the target year, the preceding year or the subsequent year may be used to comply with this annual renewable resource requirement provided that they were acquired by January 1st of the target year.~~)) A qualifying utility may use renewable energy credits to meet the provisions of this section, provided the renewable energy credits meet the following requirements:

(a) Renewable energy credits were acquired by January 1st of the target year;

(b) A renewable energy credit from electricity generated by a resource other than freshwater may be used to meet a requirement applicable to the year in which the credit was created, the year before the year in which the credit was created, or the year after the year in which the credit was created;

(c) A renewable energy credit from electricity generated by freshwater:

(i) May only be used to meet a requirement applicable to the year in which the credit was created; and

(ii) Must be acquired by the qualifying utility through ownership of the generation facility or through a transaction that conveyed both the electricity and the nonpower attributes of the electricity.

(d) A renewable energy credit transferred to an investor-owned utility pursuant to the Bonneville Power Administration's residential exchange program may not be used by any utility other than the utility receiving the credit from the Bonneville Power Administration;

(e) Each renewable energy credit may only be used once to meet the requirements of this section and must be retired using procedures of the renewable energy credit tracking system; and

(f) For purposes of this subsection, the vintage month and vintage year of the renewable energy credit represent the date the associated unit of power was generated.

(3) **WREGIS registration.** All eligible ((~~hydropower generation and all~~)) renewable ((~~energy credits~~)) resources used for utility compliance with the renewable resource target must be registered in WREGIS, regardless of facility ownership. Any ((~~megawatt-hour of eligible hydropower or~~)) renewable energy credit that a utility uses for compliance must have a corresponding certificate retired in the utility's WREGIS account.

(4) **Renewable energy credit multipliers.** The multipliers described in this subsection do not create additional renewable energy credits. A utility may count retired certificates at:

(a) One and two-tenths times the base value where the eligible resource:

(i) Commenced operation after December 31, 2005; and

(ii) The developer of the facility used apprenticeship programs approved by the Washington state apprenticeship and training council.

(b) Two times the base value where the eligible resource was generated by distributed generation and:

(i) The utility owns the distributed generation facility or has purchased the energy output and the associated renewable energy credits; or

(ii) The utility has contracted to purchase the associated renewable energy credits.

(c) A utility that uses a multiplier described in this subsection for compliance must retire the associated certificate at the same time. A utility may not transact the multipliers described in this subsection independent of the associated base value certificate.

(5) **Target calculation.** In meeting the annual targets of this section, a utility must calculate its annual target based on the average of the utility's load for the previous two years.

(6) **Integration services.** A renewable resource within the Pacific Northwest may receive integration, shaping, storage or other services from sources outside of the Pacific Northwest and remain eligible to count towards a utility's renewable resource target.

(7) **Incremental hydropower calculation.**

(a) **Method selection.** A utility must use one of the following methods to calculate the quantity of incremental electricity produced by eligible efficiency upgrades to any hydropower facility, regardless of ownership, that is used to meet the annual targets of this section. A utility shall use the same method for calculating incremental hydropower production at all of the facilities it owns. Once the commission approves a utility's method for calculating incremental hydropower production, that utility shall not use another method unless authorized by the commission.

(b) **Method one.** An annual calculation performed by:

(i) Determining the river discharge for the facility in the target year;

(ii) Measuring the total amount of electricity produced by the upgraded hydropower facility during the target year;

(iii) Using a power curve-based production model to calculate how much energy the pre-upgrade facility would have generated under the same river discharge observed in the target year; and

(iv) Subtracting the model output in (b)(iii) of this subsection from the measurement in (b)(ii) of this subsection to determine the quantity of eligible renewable energy produced by the facility during the target year.

(c) **Method two.** An annual application of a percentage to total production performed by:

(i) Determining the river discharge for the facility over a historical period of at least five consecutive years;

(ii) Using power curve-based production models to calculate the facility's generation under the river discharge of each year in the historical period for the pre-upgrade state and the post-upgrade state;

(iii) Calculating the arithmetic mean of generation in both the pre-upgrade and post-upgrade states over the historical period;

(iv) Calculating a factor by dividing the arithmetic mean post-upgrade generation by the arithmetic mean pre-upgrade generation and subtracting one; and

(v) Multiplying the facility's observed generation in the target year by the factor calculated in (c)(iv) of this subsection to determine the share of the facility's observed generation that may be reported as eligible renewable energy.

((~~(d) **Method three.** A one-time calculation of the quantity of renewable energy performed by:~~

~~(i) Determining the river discharge for the facility over a historical period of at least ten consecutive years;~~

~~(ii) Using a production model to calculate the facility's generation in megawatt-hours under the river discharge of each year in the historical period for the pre-upgrade state and the post-upgrade state;~~

~~(iii) Calculating the arithmetic mean generation of the pre-upgrade and post-upgrade states over the historical period in megawatt hours; and~~

~~(iv) Subtracting the arithmetic mean pre-upgrade generation from the arithmetic mean post-upgrade generation to determine the amount of eligible renewable generation for the target year.~~

~~(e) **Five-year evaluation.** Any utility using method three shall provide, beginning in its 2019 renewable portfolio standard report and every five years thereafter, an analysis comparing the amount of incremental hydropower the utility reported in every year using method three to the amount of incremental hydropower the utility would have reported over the same period using one of the other two methods. If the commission determines that this analysis shows a significant difference between method three and one of the other methods, it may order the utility to use a different method in the future reporting years.~~))

(8) **Qualified biomass energy.** Beginning January 1, 2016, only a utility that owns or is directly interconnected to a qualified biomass energy facility may use qualified biomass energy to meet its annual target obligation.

(a) A utility may no longer use electricity and associated renewable energy credits from a qualified biomass energy facility if the associated industrial pulping or wood manufacturing facility ceases operation other than for purposes of maintenance or upgrade.

(b) A utility may acquire renewable energy credits from a qualified biomass energy resource hosted by an industrial facility only if the facility is directly interconnected to the utility at transmission voltage. For purposes of this subsection, transmission voltage is one hundred thousand volts or higher. The number of renewable energy credits that the utility may acquire from an industrial facility for the utility's target compliance may not be greater than the utility's renewable portfolio standard percentage times the industrial facility load.

(c) A utility that owns a qualified biomass energy facility may not transfer or sell renewable energy credits associated with qualified biomass energy to another person, entity, or utility.

(9) **Use of energy output marketed by Bonneville Power Administration.** Beginning January 1, 2020, a qualifying utility may use eligible renewable resources as identified under RCW 19.285.030 (12)(g) and (h) to meet its compliance obligation under RCW 19.285.040(2). A qualifying utility may not transfer or sell eligible renewable resources obtained from the Bonneville Power Administration to another utility for compliance purposes under RCW 19.285.040.

(10) **Alternative compliance when renewable and nonemitting electric generation used to meet one hundred percent of annual retail electric load.** Pursuant to RCW 19.285.040 (2)(m), beginning January 1, 2030, a qualifying utility is considered to be in compliance with an annual renewable energy target in RCW 19.285.040 (2)(a) if the utility meets one hundred percent of the utility's average annual retail electric load using any combination of electricity from:

(a) Renewable resources and renewable energy credits as defined in RCW 19.285.030; and

(b) Nonemitting electric generation, as defined in WAC 480-109-060(23).

Nothing in subsection (10) of this section relieves the requirements of a qualifying utility to comply with the conservation targets established under RCW 19.285.040(1).

AMENDATORY SECTION (Amending WSR 15-07-043, filed 3/12/15, effective 4/12/15)

WAC 480-109-210 Renewable portfolio standard reporting. (1) **Annual report.** On or before every June 1st, each utility must file an annual renewable portfolio standard report with the commission and the department detailing the resources the utility has acquired or contracted to acquire to meet its renewable resource obligation for the target year.

(2) **Annual report contents.** The annual renewable portfolio standard report must include the utility's annual load for the prior two years, the total number of megawatt-hours from eligible renewable resources and/or renewable resource credits the utility needed to meet its annual renewable energy target by January 1st of the target year, the amount (in megawatt-hours) of each type of eligible renewable resource used, and the amount of renewable energy credits acquired. Additionally, the annual renewable portfolio standard report must include the following:

(a) **Incremental cost calculation.** To calculate its incremental cost, a utility must:

(i) Make a one-time calculation of incremental cost for each eligible resource at the time of acquisition or, for historic acquisitions, the best information available at the time of the acquisition:

(A) **Eligible resource levelized cost.** Determine the levelized cost of each eligible resource, including integration costs as determined by the utility's most recently completed renewable resource integration study, using the utility's commission-approved weighted average cost of capital at the time of the resource's acquisition as the discount rate;

(B) **Eligible resource capacity value.** Identify the capacity value of each eligible renewable resource as calculated in the utility's most recent integrated resource plan acknowledged by the commission;

(C) **Noneligible resource selection.** Select and document the lowest-reasonable-cost, noneligible resource available to the utility at the time of the eligible resource's acquisition for each corresponding eligible resource;

(D) **Noneligible levelized energy cost.** For each noneligible resource selected in (a)(i)(C) of this subsection, determine the cost of acquiring the same amount of energy as expected to be produced by the eligible resource, levelized over a time period equal to the facility life or contract length of the eligible resource and at the same discount rate used in (a)(i)(A) of this subsection;

(E) **Noneligible levelized capacity cost.** Calculate the levelized capital cost of obtaining an equivalent amount of capacity provided by the eligible resource, as determined in (a)(i)(B) of this subsection, from a noneligible resource. This cost must be levelized over a period equal to the facility life or contract length of the eligible resource and at the same discount rate used in (a)(i)(A) of this subsection. To make this calculation, a utility must use the lowest-cost, noneligible capacity resource identified in its most recent integrated resource plan acknowledged by the commission. However, if a utility determines that cost information in the integrated resource plan is no longer accurate, it may use cost information from another source, with documentation of the source and an explanation of why the source was used((.));

(F) **Calculation.** Determine the incremental cost of each eligible resource by subtracting the sum of the levelized costs of the noneligible resources calculated in (a)(i)(D) and (E) of this subsection from the levelized cost of the eligible resource determined in (a)(i)(A) of this subsection. The result of this calculation may be a negative number((.));

(G) **Legacy resources.** Any eligible resource that the utility acquired prior to March 31, 1999, is deemed to have an incremental cost of zero.

(ii) **Annual calculation of revenue requirement ratio.** To calculate its revenue requirement ratio, a utility must annually:

(A) Sum the incremental costs of all eligible resources used for target year compliance;

(B) Add the cost of any unbundled renewable energy credits purchased for target year compliance;

(C) Subtract the revenue from the sales of any renewable energy credits and energy from eligible facilities; and

(D) Divide the total obtained in (a)(ii)(A) through (C) of this subsection by the utility's annual revenue requirement, which means the revenue requirement that the commission

established in the utility's most recent rate case, and multiply by one hundred.

(iii) **Annual reporting.** In addition to the revenue requirement ratio calculated in (a)(ii) of this subsection, the utility must:

(A) Report its total incremental cost as a dollar amount and in dollars per megawatt-hour of renewable energy generated by all eligible renewable resources in the calculation in (a)(i) of this subsection; and

(B) Multiply the dollars per megawatt-hour cost calculated in (a)(iii)(A) of this subsection by the number of megawatt-hours needed for target year compliance.

(b) **Alternative compliance.** State whether the utility is relying upon one of the alternative compliance mechanisms provided in WAC 480-109-220 instead of fully meeting its renewable resource target. A utility using an alternative compliance mechanism must use the incremental cost methodology described in this section and include sufficient data, documentation and other information in its report to demonstrate that it qualifies to use that alternative mechanism.

(c) **Compliance plan.** Describe the resources that the utility intends to use to meet the renewable resource requirements for the target year.

(d) **Eligible resources.** A list of each eligible renewable resource that serves Washington customers, for which a utility owns the certificates, with an installed capacity greater than twenty-five kilowatts. Resources with an installed capacity of less than twenty-five kilowatts may be reported in terms of aggregate capacity. The list must include:

(i) Each resource's WREGIS registration status ((~~and use of certificates, whether it be for annual target compliance, a voluntary renewable energy program as provided for in RCW 19.29A.090, or owned by the customer~~)); and

(ii) Eligible resources being included in the report for the first time and documentation of their eligibility.

(e) **Multistate allocations.**

(i) If a utility serves retail customers in more than one state, the utility must allocate certificates consistent with the utility's most recent commission-approved interstate cost allocation methodology. The report must show how the utility applied the allocation methodology to arrive at the number of certificates allocated to Washington ratepayers.

(ii) After documenting the number of certificates allocated to Washington ratepayers, a utility may transfer certificates to or from Washington ratepayers. The report must document the compensation provided to each jurisdiction's ratepayers for such transfers.

(f) **Sales.** If a utility sold certificates, report the number of certificates that it sold, their WREGIS certificate numbers, their source, and the revenues obtained from the sales. For multistate utilities, these requirements only apply to certificates that were allocated to the utility's Washington service territory according to (e) of this subsection.

(3) **Report review.**

(a) Interested persons may file written comments regarding a utility's annual renewable portfolio standard report within thirty days of the utility's filing.

(b) Upon conclusion of the commission review of the utility's annual renewable portfolio standard report, the commission will issue a decision accepting or rejecting the calculation of the utility's renewable resource target; determining whether the utility has generated, acquired or arranged to acquire enough renewable energy credits or qualifying generation to comply with its renewable resource target; and determining the eligibility of new renewable resources pursuant to subsection (2)(d) of this section.

(c) If a utility revises its annual renewable portfolio standard report as a result of the commission review, the utility must submit the revised final annual renewable portfolio standard report to the department.

(4) **Publication of reports.** All renewable portfolio standard reports required by chapter 19.285 RCW and this section since January 1, 2012, must be posted and maintained on the utility's website. Reports must be posted on the utility's website within thirty days of the commission order approving the report. A copy of any such report must be provided to any person upon request.

(5) **Customer notification.** Each utility must provide a summary of its annual renewable portfolio standard report to its customers by bill insert or other suitable method. This summary must be provided within ninety days of final action by the commission on the report.

(6) **Final compliance report.** Within two years following submission of its annual renewable portfolio standard report, a utility must submit, in the same docket, a final renewable portfolio standard compliance report ((~~that~~)).

(a) The report must list((~~s~~)):

(i) The certificates that it retired in WREGIS for the target year; and

(ii) The use of certificates, whether for annual target compliance, a voluntary renewable energy program as provided for in RCW 19.29A.090, or owned by the customer.

(b) If a utility does not meet its annual target described in WAC 480-109-200, the commission will determine the amount in megawatt-hours by which the utility was deficient.

AMENDATORY SECTION (Amending WSR 15-19-032, filed 9/9/15, effective 10/10/15)

WAC 480-109-300 Greenhouse gas content calculation and energy and emissions intensity metrics. (1) A utility must report its greenhouse gas content calculation and metrics of energy and emissions intensity to the commission on or before June 1st of each year. The report must include annual values for each metric for the preceding ten calendar years. Each value reported must be based on the annual energy or emissions from all generating resources providing service to customers of that utility in Washington state, regardless of the location of the generating resources. When the metrics are calculated from generators that serve out-of-state and in-state customers, the annual energy and emissions outputs must be prorated to represent the proportion of the resource used by Washington customers.

(2) ((~~The energy and emissions intensity report~~)) Each utility must perform its greenhouse gas content calculation in accordance with the rules enacted by the department of ecology, consistent with RCW 19.405.020(22).

(3) In addition to the greenhouse gas content calculation, the report shall include the following metrics:

(a) Average megawatt-hours per residential customer;

(b) Average megawatt-hours per commercial customer;

(c) Megawatt-hours per capita;

(d) Million ((~~short~~)) metric tons of CO_2e emissions; and

(e) Comparison of annual million ((~~short~~)) metric tons of CO_2e emissions to 1990 emissions.

((~~(3) **Unknown generation sources.**~~)) (4) **Unspecified electricity.** For resources where the utility purchases energy from unknown generation sources, ((~~often called "spot market" purchases,~~)) from which the emission rates are unknown, the utility ((~~shall report emission metrics using the average electric power CO_2 emissions rate described as the net system mix (spot market) in the Washington state electric utility fuel mix disclosure reports compiled by the department pursuant to RCW 19.29A.080~~)) must use an emissions rate determined by the department of ecology. If the department of ecology has not adopted an emissions rate for unspecified electricity, a utility must apply an emissions rate of 0.437 metric tons of CO_2 per megawatt-hour of electricity. For the resources described in this subsection, a utility must show in the report required in subsection (1) of this section the following:

(a) ((~~Short~~)) Metric tons of CO_2e from unknown generation sources;

(b) Megawatt-hours delivered to its retail customers from unknown generation sources; and

(c) Percentage of total load represented by unknown generation sources.

((~~(4)~~)) (5) The greenhouse gas content calculation and energy and emissions intensity report must include narrative text and graphics describing trends and an analysis of the likely causes of changes, or lack of changes, in the metrics.

WSR 20-13-062
PROPOSED RULES
DEPARTMENT OF HEALTH
STATE BOARD OF HEALTH

[Filed June 15, 2020, 3:59 p.m.]

Supplemental Notice to WSR 20-07-108.

Preproposal statement of inquiry was filed as WSR 18-11-089.

Title of Rule and Other Identifying Information: Chapter 246-101 WAC, Notifiable conditions, supplemental notice to WSR 20-07-108. The state board of health (board) and the department of health (department) jointly propose changes to add notification and specimen submission requirements; change notification and specimen submission requirements for existing conditions; clarify notification requirements for suspected cases; revise reporting requirements for veterinarians and the Washington state department of agriculture (DOA); update references; and improve clarity and usability of the rule. This supplemental proposal adds Silicosis as a notifiable condition for health care providers and health care facilities; adds race and ethnicity to the list of required reportable data components; and makes other administrative changes and clarifications.

Hearing Location(s): On August 12, 2020, at 11:30 a.m.

In response to the coronavirus disease 2019 (COVID-19) public health emergency, the department of health and state board of health will not provide a physical location for this hearing to promote social distancing and the safety of the citizens of Washington state. A virtual public hearing, without a physical meeting space, will be held instead.

To access the meeting online: https://attendee.gotowebinar.com/register/2102821893206520331.

You can also dial-in using your phone: +1 (562) 247-8421, Access Code 260-915-447.

Date of Intended Adoption: August 12, 2020.

Submit Written Comments to: Alexandra Montano, P.O. Box 47811, Olympia, WA 98504-7811, email https://fortress.wa.gov/doh/policyreview, by July 29, 2020.

Assistance for Persons with Disabilities: Contact Alexandra Montano, phone 360-236-4205, TTY 711, email alexandra.montano@doh.wa.gov, by August 7, 2020.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The purpose [of] the chapter is to provide critical information to public health authorities to aid them in protecting and improving public health through prevention and control of infectious and noninfectious conditions as required under law. Public health authorities use the information gathered under this chapter to take appropriate action, including, but not limited to: Treating ill people; providing preventive therapies for individuals who came into contact with infectious agents; investigating and halting outbreaks; removing harmful health exposures from the environment; assessing broader health-related patterns, including historical trends, geographic clustering, and risk factors; and redirecting program activities and developing policies based on broader health-related patterns. The chapter establishes notification requirements and standards for conditions that pose a threat to public health consistent with this purpose and the authorizing statutes it is adopted under.

The current rules require health care providers, health care facilities, laboratories, veterinarians, food service establishments, child care facilities, and schools to notify public health authorities of cases of notifiable conditions identified in this chapter, cooperate with public health authorities when conducting case investigations, and follow infection control measures when necessary to control the spread of disease.

The proposed rules significantly amend notification requirements applicable to health care providers, health care facilities, laboratories, and veterinarians; create notification requirements for DOA; and clarify requirements for food service establishments, schools, child care facilities, and the general public. Proposed changes to the rules include: (1) Adding or revising notification and specimen submission requirements for seventy-four new or existing conditions; (2) eliminating three categories of conditions (other rare diseases of public health significance, emerging conditions with outbreak potential and disease of suspected bioterrorism origin); (3) eliminating notification requirements for veterinarians and clarifying requirements for veterinarians to cooperate with public health authorities during case investigations; (4) establishing notification requirements for DOA; (5) updating local health jurisdiction duties to reflect current technology used for notifying the department, clarifying existing and

establishing new notification timelines, and clarifying notification, case report, and outbreak report content requirements; (6) updating reference to the Security and Confidentiality Guidelines developed by the Centers for Disease Control and Prevention; (7) updating statutory references throughout the chapter; and (8) improving overall clarity and usability of the chapter by merging health care provider and facility rules, repealing unnecessary rules, clarifying requirements for suspected cases of notifiable conditions, and revising language consistent with clear rule writing standards.

The board held a public hearing on April 8, 2020. The board determined it would continue its consideration of the proposal until its August 12, 2020, meeting in recognition of interested parties' limited ability to comment on the proposed changes as a result of COVID-19. As a result of public comments, the board and department have made the following changes to the proposed rule since it was filed in March: Addition of Silicosis as a notifiable condition for health care providers and health care facilities; addition of race and ethnicity to the list of data components that must be included in WAC 246-101-105, 246-101-115, 246-101-205, 246-101-215, and 246-101-225; and other administrative changes and clarifications.

Reasons Supporting Proposal: The rules were last revised in 2011. Since then, there have been a number of advances and developments which can only be addressed in rule. The board and department have proposed changes to chapter 246-101 WAC to better protect public health by improving our understanding of emerging conditions, allowing more thorough case investigations, and improving the public health response to infectious and noninfectious conditions. The public health goals for these changes are to reduce the risk of transmission of disease and prevent serious complications and fatalities.

Statutory Authority for Adoption: RCW 43.20.050, 70.104.055, 43.70.545, 70.24.125, 70.104.030, 70.24.130, 70.24.380, and 70.28.032.

Statute Being Implemented: RCW 70.104.055, 43.70.545, 70.28.010, and 70.05.060.

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

Name of Proponent: Washington state board of health and Washington state department of health, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: Alexandra Montano, 101 Israel Road S.E., Tumwater, WA 98504-7990, 360-236-4205.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Alexandra Montano, P.O. Box 47811, Olympia, WA 98504-7811, phone 360-236-4205, TTY 711, email alexandra.montano@doh.wa.gov.

The proposed rule does impose more-than-minor costs on businesses.

Small Business Economic Impact Statement

The purpose of chapter 246-101 WAC, Notifiable conditions, is to provide critical information to public health authorities to aid them in protecting and improving public health through prevention and control of infectious and noninfectious conditions as required under RCW 43.20.050, 70.104.055, and 43.70.545. Public health authorities use the information gathered under this chapter to take appropriate action, including, but not limited to, treating ill people; providing preventive therapies for individuals who came into contact with infectious agents; investigating and halting outbreaks; removing harmful health exposures from the environment; assessing broader health-related patterns, including historical trends, geographic clustering, and risk factors; and redirecting program activities and developing policies based on broader health-related patterns. The chapter establishes notification requirements and standards for conditions that pose a threat to public health consistent with this purpose and the authorizing statutes it is adopted under.

The current rules require health care providers, health care facilities, laboratories, veterinarians, food service establishments, child care facilities, and schools to notify public health authorities of cases of notifiable conditions identified in chapter 246-101 WAC, cooperate with public health authorities when conducting case investigations, and follow infection control measures when necessary to control the spread of disease.

The rules were last revised in 2011. Since then, there have been a number of advances and developments which can only be addressed in rule. The board and department, through joint rule making, have proposed changes to chapter 246-101 WAC, Notifiable conditions, to better protect public health by improving our understanding of emerging conditions, allowing more thorough case investigations, and improving the public health response to infectious and noninfectious conditions. The public health goals for these changes are to reduce the risk of transmission of disease and prevent serious complications and fatalities.

If adopted, the proposed rules would significantly amend notification requirements applicable to health care providers, health care facilities, laboratories, and veterinarians; create notification requirements for DOA; and clarify requirements for food service establishments, schools, child care facilities, and the general public. Proposed changes to the rules include:

- Adding or revising notification and specimen submission requirements for seventy-four new or existing conditions;
- Adding race and ethnicity to the list of data components that must be reported;
- Eliminating three categories of conditions (other rare diseases of public health significance, emerging conditions with outbreak potential, and disease of suspected bioterrorism origin);
- Eliminating notification requirements for veterinarians and clarifying requirements for veterinarians to cooperate with public health authorities during case investigations;
- Establishing notification requirements for DOA;
- Updating local health jurisdiction duties to reflect current technology used for notifying the department, clarifying existing and establishing new notification timelines, and clarifying notification, case report, and outbreak report content requirements;

- Updating reference to the Security and Confidentiality Guidelines developed by the Centers for Disease Control and Prevention;
- Updating statutory references throughout the chapter; and
- Improving overall clarity and usability of the chapter by merging health care provider and facility rules, repealing unnecessary rules, clarifying requirements for suspected cases of notifiable conditions, and revising language consistent with clear rule writing standards.

The board held a public hearing on April 8, 2020. As a result of the hearing the board determined it would file a supplemental proposal to CR-102 filed on March 18, 2020, as WSR 20-07-108. The supplemental proposal:

- Continues the board's consideration of the original proposal until its August 12, 2020, meeting in recognition of interested parties' limited ability to comment on the proposed changes as a result of the coronavirus disease (COVID-19) pandemic; and
- Proposes further amendments to the rule, including:
  - Adding Silicosis as a notifiable condition for healthcare providers and healthcare facilities. This analysis, includes assumed probable costs for health care providers and facilities to prepare and submit cases.
  - Adding race and ethnicity to the list of data components that must be included in reports as required in WAC 246-101-105, 246-101-115, 246-101-205, 246-101-215, and 246-101-225. The department assumes that even with adding these additional data components the proposed changes will not add any new costs for health care providers and facilities.
  - Other administrative changes and clarifications. No new costs are associated with these amendments.

The following businesses are required to comply with the proposed rule. The North American Industry Classification System (NAICS) codes were used and the minor cost thresholds are identified.

Table A:

NAICS Code (4, 5 or 6 digit)	NAICS Business Description	# of Businesses in WA	Minor Cost Threshold = 1% of Average Annual Payroll	Minor Cost Threshold = .3% of Average Annual Receipts
621111	Offices of physicians (except mental health specialists)	2576	$19,450.07	$5,891.42
621112	Offices of physicians; mental health specialists	130	$2,243.26	$727.85
621330	Offices of mental health practitioners (except physicians)	235	$2,665.03	$351.33
621399	Offices of all other miscellaneous health practitioners	1042	$1,482.68	$528.32
621410	Family planning centers	53	$6,906.27	$2,106.01
621420	Outpatient mental health and substance abuse centers	329	$14,653.15	$1,830.45
621491	HMO medical centers	71	Redacted	$51,522.51
621492	Kidney dialysis centers	105	$21,245.21	$59,055.28
621493	Freestanding ambulatory surgical and emergency centers	58	Redacted	$12,617.37
621498	All other outpatient care centers	110	$33,260.62	$2,370.09
621511	Medical laboratories	192	$15,104.13	$17,874.80
621910	Ambulance services	52	$24,603.63	$7,390.03
621991	Blood and organ banks	37	$35,058.86	$3,564.01
621999	All other miscellaneous ambulatory health care services	59	Redacted	$4,185.45
622110	General medical and surgical hospitals	147	$622,801.12	$156,044.36
622210	Psychiatric and substance abuse hospitals	28	$41,280.23	$10,762.16
622310	Specialty (except psychiatric and substance abuse) hospitals	6	$303,145.51	$15,972.98
623110	Nursing care facilities (skilled nursing facilities)	258	$33,681.92	$7,099.53

Probable cost of compliance including: Cost of equipment, supplies, labor, professional services and increased administrative costs; and whether compliance with the proposed rule will cause businesses to lose sales or revenue.

WAC 246-101-101 Notifiable conditions—Health care providers and facilities, and 246-101-201 Notifiable conditions—Laboratories. The proposed rules require health care providers, health care facilities, and laboratories to submit case reports and specimens to public health authorities for specified conditions, within specified timeframes, with specified information, and using a specified format. The rules do not require health care providers, health care facilities, or laboratories to provide service or conduct laboratory tests that they do not include as a part of their business practices. Table 1 outlines the probable costs by condition (per case) along with the total annual costs by condition. Table 2 outlines the additional probable one-time costs for providers, facilities, and laboratories for training and for updating Standard Operating Procedures, Laboratory Information Management Systems (LIMS), and Electronic Laboratory Reporting (ELR) systems.

Table 1: Probable Annual Costs (WAC 246-101-101, 246-101-105, 246-101-115, 246-101-201, 246-101-205, 246-101-215, 246-101-225)

Condition	**Providers/Facilities: Added Cost per Case Report**[1]	**Laboratories: Added Cost per Case Report**[2]	**Laboratories: Added Cost per Specimen Submission**[3]	**Assumed Number of Cases per Year**[4]	**Total Annual Cost per Condition**
Amoebic meningitis	$0 - $82.50	$0 - $30.00	$0 - $15.00	0 - 1	$0 - $127.50
Anaplasmosis	$0 - 412.50	$0 - 100.00	$0 - $75.00	0 - 5	$0 - $587.50
Babesiosis	$0 - $247.50	$0 - $60.00	$0 - $45.00	0 - 3	$0 - $352.50
Bacillus cereus (biovar anthracis only)	$0 - $82.50	$0 - $30.00	$0	0 - 1	$0 - $112.50
Baylisascariasis	$0 - $82.50	$30.00	$15.00	1	$0 - $127.50
Blood lead level (adult between 5 µg/dl and 10 µg/dl)	N/A	$8,000 - $10,000	N/A	400 - 500	$8,000 - $10,000
Bordetella pertussis	N/A	$0	$0	Fewer notifications	$0
Borrelia burgdorferi or mayonii	N/A	$0 - $20.00	$0 - $15.00	0 - 1	$0 - $35.00
Brucella species	N/A	$0 - $20.00	$0 - $15.00	0 - 1	$0 - $35.00
Burkholderia mallei	N/A	$0	$0	Fewer notifications	$0
Burkholderia pseudomallei	N/A	$0	$0	Fewer notifications	$0
California serogroup viruses	N/A	$0 - $20.00	$0 - $15	0 - 1	$0 - $35.00
Campylobacteriosis	$0[5]	$0	$0	Fewer test results	$0
Candida auris	$1,402.50	$510.00	$255.00	17	$2,167.50
Carbapenem-resistant Enterobacteriaceae: Klebsiella species, E. coli, Enterobacter species	$24,750.00	$6,000.00	$4,500.00	300	$35,250.00
Chagas disease (Trypanosoma cruzi)	$825.00 - $1,650.00	$200 - $400	$150 - $300	10 - 20	$1,175 - $3,525
Chikungunya virus	N/A	$0 - $100	$0 - $75	0 - 5	$0 - $175.00

Condition	Providers/Facilities: Added Cost per Case Report[1]	Laboratories: Added Cost per Case Report[2]	Laboratories: Added Cost per Specimen Submission[3]	Assumed Number of Cases per Year[4]	Total Annual Cost per Condition
Chlamydia trachomatis	N/A	$10,000	$0	500	$10,000
Chlamydia trachomatis (De-identified negative results)	N/A	$162,240	$0	5,408	$167,648
Coccidioidomycosis (Coccidioides)	$4,125.00 - $6,600.00	$1,000.00 - $1,600.00	$750.00 - 1,200.00	-50-80	$5,875 - $9,400
Coronavirus: MERS-associated	$82.50	$60.00	$50.00	2	$192.50
Coronavirus: Novel coronavirus (COVID-19)	$8,250.00 - $82,500.00	$3,000.00 - $30,000.00	$2,5000.00 [$2,500.00] - $25,000.00	100 - 1000 (estimate based on very limited data)	$13,750.00 - $137,500.00
Cryptococcus gattii	$82.50 - $825.00	$20.00 - $200.00	$0	1 - 10	$102.50 - $1,025.00
Cysticercosis	$0 - $165.00	N/A	N/A	0 - 2	$0 - $165.00
Dengue viruses	N/A	$0 - $60.00	$0 - $45.00	0 - 3	$0 - $125.00
Diphtheria (Corynebacterium Diphtheria)	N/A	$0	$0	Fewer notifications	$0
Eastern and western equine encephalitis virus	N/A	$0 - $20.00	$0 - $15.00	0 - 1	$0 - $35.00
Echinococcosis (Echinococcus granulosus or multilocularis)	$0 - $82.50	$0.00 - $20.00	$0.00 - $15.00	0 - 1	$0 - $117.50
Ehrlichiosis (Ehrlichia species)	$0 -165.00	$0 - $40.00	$0 - $30.00	0 - 2	$0 - $235.00
Gonorrhea (Neisseria gonorrhoeae)	$0	$1,400.00	$0	70	$1,400.00
Gonorrhea (Neisseria gonorrhoeae) (De-identified negative results)	N/A	$106,380	$0	3,546	$106,380.00
Haemophilus influenzae (children <5 years of age)	N/A	$0	$0	Fewer notifications	$0
Hantaviral infections	$0	$0	$0 - $75.00	0 - 5	$0 - $75
Hepatitis A virus	N/A	$60.00 - $120.00	$30.00 - $60.00	2 - 4	$90.00 - $180.00
Hepatitis B (chronic)	$0	N/A	N/A	1,521	$0
Hepatitis B virus	N/A	$30,680	N/A	1,547	$30,680.00
Hepatitis C (acute), (chronic), and (perinatal)	$0	N/A	N/A	N/A	$0

Condition	**Providers/Facilities: Added Cost per Case Report**[1]	**Laboratories: Added Cost per Case Report**[2]	**Laboratories: Added Cost per Specimen Submission**[3]	**Assumed Number of Cases per Year**[4]	**Total Annual Cost per Condition**
Hepatitis C virus	N/A	$330,848	$0	7,712 positives and 15,000 nonpositive results for nucleic acid detection tests	$330,848
Hepatitis C virus (De-identified negative results)	N/A	$478,590	$0	145,953	$478,590.00
Hepatitis D	$0	$140	$0	14	$140
Histoplasmosis (Histoplasma capsulatum)	$82.50	$0.00 - $20.00	$0 - $25.00	0 - 1	$82.50 - $127.50.00 [$127.50]
HIV	N/A	$61,708	$0	13,752	$61,708.00
HIV (De-identified negative results)	N/A	$419,940	$0	13,998	$419,940.00
Human prion disease	N/A	$400.00	$500.00	20	$900.00
Hypersensitivity Pneumonitis, Occupational	$1567.50 - $2392.50	N/A	N/A	19 - 29	$1567.50 - $2392.50
Japanese encephalitis virus	N/A	$0 - $20.00	$0 - $15.00	0 - 1	$0 - $35.00
La Crosse encephalitis virus	N/A	$0 - $20.00	$0 - $15.00	0 - 1	$0 - $35.00
Listeriosis (Listeria monocytogenes)	N/A	$0	$0	Fewer notifications	$0
Malaria (Plasmodium species)	N/A	$0	$0	Fewer notifications	$0
Mumps virus	N/A	$0	$0	No change in number of notifications	$0
Powassan virus	N/A	$0.00 - $20.00	$0 - $15.00	0 - 1	$0 - $35.00
Psittacosis (Chlamydia psittaci)	N/A	$0	$0	Fewer notifications	$0
Relapsing fever (Borrelia hermsii, miyamotoi, or recurrentis)	$0	$0 - $20.00	$0 - $15.00	0 - 1	$0 - $35.00
Rickettsia infection (Rickettsia species)	$0 - $412.50	$100.00	$75.00	0 - 5	$0 - $587.50
Rubella	N/A	$0 - $60.00	$0 - $30.00	0 - 2	$0 - $90.00

Condition	**Providers/Facilities: Added Cost per Case Report**[1]	**Laboratories: Added Cost per Case Report**[2]	**Laboratories: Added Cost per Specimen Submission**[3]	**Assumed Number of Cases per Year**[4]	**Total Annual Cost per Condition**
Rubeola (Measles virus)	N/A	$0	$0	No change in number of notifications	$0
Silicosis	$82.50 - $660	N/A	N/A	1 - 8	$82.50 to $660
Smallpox (Variola virus)	N/A	$0.00 - $150.00	$0 - $75.00	0 - 5	$0 - $225.00
St. Louis encephalitis virus	N/A	$0.00 - $20.00	$0 - $15.00	0 - 1	$0 - $35.00
Syphilis (Treponema pallidum)	N/A	$120.00	$0	6	$120.00
Syphilis (Treponema pallidum) (De-identified negatives)	N/A	$42,980	$0	14,766	$42,980.00
Taenia solium	See Cysticercosis and Taeniasis	$400.00	$300.00	20	$700.00
Taeniasis	$0 - $412.50	N/A	N/A	0 - 5	$0 - $412.50
Tick paralysis	$0 - $165.00	N/A	N/A	0 - 2	$0 - $165.00
Trichinellosis (Trichinella species)	N/A	$0	$0	Fewer notifications	$0
Tuberculosis (Mycobacterium tuberculosis complex)	$0	$0	$0	Fewer notifications	$0
Typhus	$82.50	N/A	N/A	1	$82.50
Vaccinia (vaccine-acquired smallpox)	N/A	$0 - $150.00	$0 - $125.00	0 - 5	$0 - $275.00
West Nile virus	N/A	$0	$0	Fewer notifications	$0
Yellow fever virus	N/A	$0	$0	Fewer notifications	$0
Zika virus	N/A	$0 - $1,380.00	$0 - $1,035.00	0 - 69	$0 - $2,415.00
RANGE OF TOTAL PROBABLE COSTS FOR ALL REGULATED ENTITIES IN THE STATE COMBINED					$1,720,451.50 - $1,860,721.50

1 Costs are for staff time to prepare the case report.

2 Costs are for staff time to prepare the case report.

3 Costs are for staff time to prepare documentation to accompany specimens and packaging materials.

4 For rare conditions, such as anthrax, that have not occurred in Washington state, the department assumed a single case per year to provide a cost estimate in the event a case of the condition ever occurs.

5 New condition for health care facilities only.

Table 2: Probable One-time Costs (WAC 246-101-101, 246-101-105, 246-101-115, 246-101-201, 246-101-205, 246-101-215, 246-101-225)

Cost Description	Providers / Facilities	Laboratories:
Update standard operating procedures	N/A	74 conditions X $12 = $888
Update laboratory information management systems	N/A	74 conditions X $60 = $4,440
Update electronic laboratory reporting	N/A	74 conditions X $60 = $4,440
Create de-identified annual summary report in LIMS	N/A	5 conditions X $800 = $40,000
Total cost per regulated entity	$0	$49,768

WAC 246-101-105, Duties: Health care providers and facilities, 246-101-115, Content of case reports: Health care providers and health care facilities, 246-101-205, Duties: Laboratory directors. The proposed rules amend multiple sections in order to establish consistent content of health care provider, facility, and laboratory case reports and specimen submission forms. The only exception to this proposed standard is WAC 246-101-118, Content of case reports for occupational traumatic injury hospitalizations: Health care facilities. The costs of these changes are included in Table 1: Probable Annual Costs (WAC 246-101-101, 246-101-105, 246-101-115, 246-101-201, 246-101-205, 246-101-215, 246-101-225), and Table 2: Probable One-time Costs (WAC 246-101-101, 246-101-105, 246-101-115, 246-101-201, 246-101-205, 246-101-215, 246-101-225) above.

WAC 246-101-110, Means of notification: Health care providers and health care facilities. The proposed rule requires all case reports be type written. This change would eliminate hand-written case reports. The department assumes that by providing electronic forms on its website, the proposed change is cost neutral for health care providers and facilities.

WAC 246-101-205, Duties: Laboratory directors. The proposed rule requires laboratories to submit presumptive and final test results to the department for a patient residing outside and visiting Washington state. The department assumes the probable cost for a laboratory to prepare and submit case reports for patients visiting Washington state are included in costs identified in Table 1 and Table 2 for updating laboratory LIMS and ELR systems, updating standard operating procedures for each notifiable condition, and confirming receipt for case reports for conditions notifiable immediately or within 24 hours.

WAC 246-101-220, Means of notification: Laboratory directors. The proposed rule requires all presumptive and final test results be submitted via secure electronic data transmission. This change would eliminate hand-written presumptive and final test results, and nonelectronic mail submission (e.g. USPS, FedEx, UPS, etc.). The department assumes that by providing electronic forms on its website, the proposed change to eliminate hand-written test results is cost neutral for health care providers and facilities. The department also assumes the proposed requirement to use secure electronic data submission of test results is the standard for laboratories to share sensitive data and the probable cost for this change is negligible.

WAC 246-101-405, Duties: Veterinarians and the state department of agriculture. The proposed rule eliminates the requirement for veterinarians to notify the department of suspected human cases of specifically named zoonotic diseases that pose a high risk of transmission to humans. The department has historically received no case reports from veterinarians under this requirement and assumes there will be no increased or decreased cost for this proposed change.

Probable Benefit and Cost Conclusion: The department and board evaluated the qualitative [quantitative] and qualitative costs and benefits of the proposed rules, taking into account the general goals and specific objectives of the statute being implemented.

Benefit Summary: The proposed rules implement the general goals and specific objectives of RCW 43.20.050, 43.70.545, and 70.104.055 by establishing a surveillance system that includes notification, investigation, and collection and distribution of data related to infectious and noninfectious conditions. This data is critical to local health jurisdictions, the department, and other public health authorities tasked with preventing and controlling the spread of disease. Public health authorities also use the data to assess broader patterns, including historical trends and geographic clustering of disease. Based on these assessments, officials are able to take appropriate actions such as conducting outbreak investigations, redirecting program activities, and developing new policies to prevent and control infectious and noninfectious conditions.

Public health surveillance plays an essential role in disease control by providing public health authorities with information and data necessary to take public health action. Surveillance provides data and information to assess the burden and distribution of adverse health events, prioritize public health actions, implement disease control measures to reduce the number and severity of cases, monitor the impact of control measures, identify reservoirs or vectors of disease, identify emerging health conditions that may have a significant impact upon population health, and contribute to surveillance activities at the national and international level to implement more effective control measures on a broader scale.

6 Groseclose SL, Buckeridge DL. Public health surveillance systems: recent advances in their use and evaluation. Annual Rev Public Health. 2017; 38:57-79.

Public health surveillance plays a key role in identifying, controlling, and preventing the spread of zoonotic disease and can also play a role in promoting equity. Many of the new conditions in the proposed rules disproportionality [disproportionately] impact subpopulations who are already experiencing health disparities as documented in this analysis. The proposed rules establish notification requirements for new conditions and revised notification and specimen submission

requirements for some current conditions. These changes are help [helpful] to avoid the costs associated with the burden on an individual with a case of a condition, the public health system, and the population as a whole.

Cost Summary: The proposed rules impose new costs for health care providers, health care facilities, and laboratories for new requirements related to case reports and specimens submitted under the proposed rules. Below is a summary of the costs described in the preceding section-by-section analysis.

The probable one-time cost per entity is $0 for providers/facilities and $49,768 for non-CLIA waived laboratories (Table 2). The estimate for each laboratory is likely inflated due to the fact that some laboratories do not test for many of the conditions and will not include the one-time costs of updating their systems. In addition, some one-time costs are specific to laboratories using ELR (not exclusively, but primarily large labs). The department assumes that some laboratories will incur zero one-time costs associated with the proposed amendments, with any one lab incurring no more than $49,768 in one-time costs. In addition to these one-time costs, the probable annual costs for all regulated entities in Washington state combined (Table 1) range from $1,720, 451.50 - $1,860,721.50. No one entity will absorb all of these costs. As noted above, the department assumes some regulated entities (e.g. laboratories who do not test for notifiable conditions, or health care providers who do not diagnose notifiable conditions) will incur zero costs. The annual costs of the rules statewide will be distributed among the remaining businesses, with larger entities likely to incur the largest costs due to higher testing volumes. Three healthcare providers/facilities provided annual cost estimates in the cost questionnaires. These estimates were $72.80, $100 (respondent did not indicate number of employees), and $574 annually. One laboratory (>5000 employees) estimated that the proposed changes would cost them $12,000 - $15,000 in one-time costs and $2,500 - $5,000 in annual costs.

Analysis of whether the proposed rule may impose more than minor costs on businesses in the industry: Based on the minor cost thresholds and the summary of costs identified above, the department and board assume that the proposed rules will impose more than minor costs on the businesses in the industry.

Determination of whether the proposed rule may have a disproportionate impact on small businesses as compared to the ten percent of businesses that are the largest businesses required to comply with the proposed rule: Based on the minor cost thresholds and the summary of costs identified above, the department and board assume that the proposed rules will have a disproportionate impact on small businesses as compared to the ten percent of businesses that are the largest required to comply with the proposed rules.

The following steps were taken to reduce the costs of the rule on small businesses. If the costs could not be reduced, an explanation of why was provided. Electronic Laboratory Reporting (ELR): ***Alternative 1: Mandatory Electronic Laboratory Reporting using HL7 Messaging with Mitigating Measures for Small Laboratories****:* The board and department considered mandating laboratory submission of test results using HL7 messaging, and including mitigating measures for small laboratories that allow those businesses to submit results using a less costly method. The benefit of this approach is that it would move a majority of the reporting to HL7 messaging, which would improve timelines of reporting and reduce the burden on local health jurisdictions and the department, freeing up limited public health resources to promote public health. This approach would simultaneously mitigate the costs for small laboratories that do not have capacity to acquire and maintain a costly HL7 system.

However, there are a number of barriers to using this approach. This alternative would require the board and department to define a small laboratory based on income or number of employees. This is not necessarily a proxy for the number of notifiable conditions a laboratory reports each year, so this approach could require a laboratory to invest in an expensive ELR system even if they only submit a small number of notifiable conditions each year. In addition, some laboratories are part of hospitals which have a large number of employees, but the board and department heard from the TAC that this does not mean that the laboratory itself has a large staff or operating budget. Using the number of notifiable conditions reported each year as a way to define small laboratories versus large laboratories would be an inaccurate measure of a laboratory's budget and their ability to absorb the costs of mandatory HL7 as a small lab could report a large number of cases each year. Using number of case reports to define laboratory size is not only inaccurate and unenforceable (because the decentralized reporting system in Washington state makes it challenging to track how many cases are submitted by any one laboratory to determine if they meet the definition of a large business), but also creates a potential incentive for labs to underreport in order to stay below the large laboratory threshold. The fact that health care providers and others conducting Rapid Screening Tests (RST) are also laboratories under the rule further complicates this alternative.

Alternative 2: Mandatory Electronic Laboratory Reporting with Three Reporting Options*:* In order to maintain the benefits outlined above while addressing the challenges, the board and department considered allowing all laboratories to choose reporting methods from the following options:

- **Option A:** HL7 according to the most recent HL7 national guidelines, or
- **Option B:** Department created and maintained web-submitter that would convert the data into HL7, or
- **Option C (for blood lead RST results only):** A[n] Excel spreadsheet or similar electronic format allowing RST results to be submitted via secure electronic data transmission.

While this alternative would provide a less costly option for small laboratories or laboratories who report a small number of cases each year, there was no way to guarantee that the web-submitter would be operational by the time the rule went into effect. Without the web-submitter, this alternative would not have provided adequate mitigation for small businesses.

***Alterative [Alternative] 3: Maintain the Status Quo**:* The status quo allows laboratories to submit case reports using HL7 or using other formats (e.g. postal service). While this would be the least burdensome alternative for laboratories, this option would not allow the public health benefits outlined above (e.g. increased timeless [timeliness] and accuracy of reporting) and would continue to allow hand-written case reports, which create issues with legibility and increased risk of data entry errors. This alternative does not provided the needed public health benefits.

***Alternative 4: Remove Secure Facsimile, Postal Mail, and Handwritten Case Report as Options for Submitting Case Reports, but Do Not Mandate Electronic Lab Reporting Using HL7 Messaging**:* This option has potential to improve timeliness of notification and data accuracy for laboratory reports, particularly for those submitting RST results, (e.g., fewer legibility issues and manual data entry errors; more complete information; more usable and consistent information due to the use of department standardized tools) and to reduce the burden on local health jurisdictions and the department of processing paper reports thereby freeing up limited public health resources to promote public health.

However, we learned that many laboratories who have not already moved to ELR through HL7, including the state public health laboratories and those reporting using RST (such as ECEAP programs which submit large volumes of lead tests) still rely heavily on facsimile to submit case reports. The lead program at the department has had great success in helping laboratories move away from facsimile toward other electronic methods of submission (e.g. secure email using a standardized spreadsheet format provided by the department) through relationship-building and technical assistance. There are opportunities to work with laboratories to help them voluntarily move away from facsimile, and to continue to pursue a web-submitter resource, before removing this frequently used reporting method through rule. The board and department determined that removing the postal mail and handwritten case reports as options at this time, but allowing the continued use of secure facsimile, was the least burdensome alternative that still created the benefits of increased timeliness and accuracy of reporting.

Description of how small businesses were involved in the development of the proposed rule: The department and board requested participation from small business on the TAC that provided professional expertise and recommendations for revision of the notifiable conditions rules, chapter 246-101 WAC. In addition, the Association of Community and Migrant Health Centers and the Commission on Hispanic Affairs participated in the TAC. The department and board also requested comments and cost estimates on the draft rules from licensed health care providers, health care facilities, and laboratories. In addition, staff contacted small laboratories and facilitates via email and phone in an effort to receive feedback on the rules, both content and cost.

Estimated number of jobs that will be created or lost as the result of compliance with the proposed rule: The department and board estimate no jobs will be created or lost as the result of compliance with the proposed rules.

A copy of the statement may be obtained by contacting Alexandra Montano, P.O. Box 47811, Olympia, WA 98504-7811, phone 360-236-4205, TTY 711, email alexandra.montano@doh.wa.gov.

June 15, 2020
Michelle A. Davis
and Jessica Todorovich
for John Wiesman, DrPH, MPH
State Board of Health Executive Director
and Chief of Staff for Secretary of Health

PART I: GENERAL PROVISIONS

AMENDATORY SECTION (Amending WSR 00-23-120, filed 11/22/00, effective 12/23/00)

WAC 246-101-005 Purpose ((~~of notifiable conditions reporting~~)) and scope. (1) The purpose of ((~~notifiable conditions reporting~~)) this chapter is to provide ((~~the information necessary for public health officials to protect the public's health by tracking communicable diseases and other conditions. These data are critical to local health departments and the departments of health and labor and industries in their efforts to prevent and control the spread of diseases and other conditions. Public health officials take steps to protect the public, based on these notifications. Treating persons already ill, providing preventive therapies for individuals who came into contact with infectious agents, investigating and halting outbreaks, and removing harmful health exposures are key ways public health officials protect the public. Public health workers also use these data to assess broader patterns, including historical trends and geographic clustering. By analyzing the broader picture, officials are able to take appropriate actions, including outbreak investigation, redirection of program activities, or policy development~~)) critical information to public health authorities to aid them in protecting and improving the public's health through prevention and control of infectious and noninfectious conditions. Public health authorities use the information gathered under this chapter to take appropriate action including, but not limited to:

(a) Treating ill persons;

(b) Providing preventive therapies for individuals who came into contact with infectious agents;

(c) Investigating and halting outbreaks;

(d) Removing harmful health exposures from the environment;

(e) Assessing broader health-related patterns, including historical trends, geographic clustering, and risk factors; and

(f) Redirecting program activities and developing policies based on broader health-related patterns.

(2) This chapter establishes notification requirements and standards for conditions that pose a threat to public health consistent with the purpose as established in this section.

AMENDATORY SECTION (Amending WSR 14-11-009, filed 5/8/14, effective 6/8/14)

WAC 246-101-010 Definitions ((~~within the notifiable conditions regulations~~)), abbreviations, and acronyms. The ((~~following~~)) definitions, abbreviations, and acronyms in this section apply ((~~in the interpretation and enforcement of~~))

throughout this chapter unless the context clearly requires otherwise:

(1) "Animal case" means an animal, alive or dead, with a diagnosis or suspected diagnosis of a notifiable condition in Table Agriculture-1 of WAC 246-101-805 made by a veterinarian licensed under chapter 18.92 RCW, veterinary medical facility licensed under chapter 18.92 RCW, or veterinary laboratory as defined under chapter 16.70 RCW based on clinical criteria, or laboratory criteria, or both.

(2) "Associated death" means a death resulting directly or indirectly from ((~~the confirmed condition of influenza or varicella. There should be~~)) a confirmed case of the specified condition, with no period of complete recovery between the ((~~illness~~)) onset of the condition and death.

(((~~2~~))) (3) "Blood lead level" means a measurement of lead content in whole blood.

(((~~3~~))) (4) "Board" means the Washington state board of health.

(((~~4~~))) (5) "Business day" means any day that the department is open for business.

(6) "Carrier" means a person harboring a specific infectious agent without developing symptoms and serving as a potential source of infection to others.

(((~~5~~))) (7) "Case" means a person, alive or dead, ((~~diagnosed~~)) with a ((~~particular disease or~~)) diagnosis or suspected diagnosis of a condition made by a health care provider ((~~with diagnosis~~)), health care facility, or laboratory based on clinical criteria, or laboratory criteria, or both, such as the Centers for Disease Control and Prevention, National Notifiable Diseases Surveillance System, Council of State and Territorial Epidemiologists case definitions.

(((~~6) "Child day care facility" means an agency regularly providing care for a group of children for less than twenty-four hours a day and subject to licensing under chapter 74.15 RCW.~~

~~(7) "Condition notifiable within three business days" means a notifiable condition that must be reported to the local health officer or the department within three business days following date of diagnosis. For example, if a condition notifiable within three business days is diagnosed on a Friday afternoon, the report must be submitted by the following Wednesday.~~))

(8) "Communicable disease" means ((~~a~~)) an infectious disease ((~~caused by an infectious agent~~)) that can be transmitted from ((~~one~~)) a person, animal, or object to ((~~another~~)) a person by direct or indirect means including, but not limited to, transmission through an intermediate host or vector, food, water, or air.

(9) ((~~"Contact" means a person exposed to an infected person, animal, or contaminated environment that may lead to infection.~~

~~(10)~~)) "Condition" means an infectious or noninfectious condition as these terms are defined in this chapter.

(10) "Department" or "DOH" means the Washington state department of health.

(11) ((~~"Disease of suspected bioterrorism origin" means a disease caused by viruses, bacteria, fungi, or toxins from living organisms that are used to produce death or disease in humans, animals, or plants. Many of these diseases may have nonspecific presenting symptoms. The following situations could represent a possible bioterrorism event and should be reported immediately to the local health department:~~

~~(a) A single diagnosed or strongly suspected case of disease caused by an uncommon agent or a potential agent of bioterrorism occurring in a patient with no known risk factors;~~

~~(b) A cluster of patients presenting with a similar syndrome that includes unusual disease characteristics or unusually high morbidity or mortality without obvious etiology; or~~

~~(c) Unexplained increase in a common syndrome above seasonally expected levels.~~

~~(12) "Elevated blood lead level" means blood lead levels equal to or greater than 10 micrograms per deciliter for persons aged fifteen years or older, or equal to or greater than 5 micrograms per deciliter in children less than fifteen years of age.~~

~~(13) "Emerging condition with outbreak potential" means a newly identified condition with potential for person-to-person transmission.~~

~~(14) "Food service establishment" means a place, location, operation, site, or facility where food is manufactured, prepared, processed, packaged, dispensed, distributed, sold, served, or offered to the consumer regardless of whether or not compensation for food occurs.~~

~~(15)~~)) "Health care-associated infection" means an infection acquired from contaminated products, devices, or food products in a health care facility.

(((~~16~~))) (12) "Health care facility" means:

(a) Any assisted living facility licensed under chapter 18.20 RCW; birthing center licensed under chapter 18.46 RCW; nursing home licensed under chapter 18.51 RCW; hospital licensed under chapter 70.41 RCW; adult family home licensed under chapter 70.128 RCW; ambulatory surgical facility licensed under chapter 70.230 RCW; or private establishment licensed under chapter 71.12 RCW;

(b) Clinics, or other settings where one or more health care providers practice; and

(c) In reference to a sexually transmitted ((~~disease~~)) infection, other settings as defined in chapter 70.24 RCW.

(((~~17~~))) (13) "Health care provider" means any person having direct or supervisory responsibility for the delivery of health care whose scope of practice allows for diagnosis and treatment of notifiable conditions and who is:

(a) Licensed or certified in this state under Title 18 RCW; or

(b) Military personnel providing health care within the state regardless of licensure.

(((~~18) "Health care services to the patient" means treatment, consultation, or intervention for patient care.~~

~~(19) "Health carrier" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, or a health maintenance organization as defined in RCW 48.46.020.~~

~~(20) "HIV testing" means conducting a laboratory test or sequence of tests to detect the human immunodeficiency virus (HIV) or antibodies to HIV performed in accordance with requirements to WAC 246-100-207. To assure that the protection, including, but not limited to, pre- and post-test counseling, consent, and confidentiality afforded to HIV testing as described in chapter 246-100 WAC also applies to the~~

~~enumeration of CD4 + (T4) lymphocyte counts (CD4 + counts) and CD4 + (T4) percents of total lymphocytes (CD4 + percents) when used to diagnose HIV infection, CD4 + counts and CD4 + percents will be presumed HIV testing except when shown by clear and convincing evidence to be for use in the following circumstances:~~

~~(a) Monitoring previously diagnosed infection with HIV;~~

~~(b) Monitoring organ or bone marrow transplants;~~

~~(c) Monitoring chemotherapy;~~

~~(d) Medical research; or~~

~~(e) Diagnosis or monitoring of congenital immunodeficiency states or autoimmune states not related to HIV.~~

~~The burden of proving the existence of one or more of the circumstances identified in (a) through (e) of this subsection shall be on the person asserting the existence.~~

~~(21)~~)) (14) "Immediately ((~~notifiable condition~~))" means ((~~a notifiable condition of urgent public health importance, a case or suspected case of which must be reported to the local health officer or the department~~)) without delay, twenty-four hours a day, seven days a week.

(a) For health care providers and health care facilities, immediately means at the time ((~~of diagnosis or suspected diagnosis, twenty-four hours a day, seven days a week~~)) a case is identified;

(b) For laboratories, immediately means upon receiving a presumptive or final test result; or

(c) For state agencies and local health jurisdictions, immediately means upon receiving notification of a case.

(((~~22~~))) (15) "Infection control measures" means the management of an infected person((~~s~~)), or of a person suspected to be infected, and others in a manner to prevent transmission of the infectious agent. Infection control measures include, but are not limited to, isolation and quarantine.

(16) "Infectious condition" means a disease caused by a pathogenic organism such as bacteria, virus, fungus, or parasite, and includes communicable disease and zoonotic disease.

(17) "Influenza, novel" or "influenza virus, novel" means a human infection with an influenza A virus subtype that is different from currently circulating human influenza subtypes. Novel subtypes include, but are not limited to, H2, H5, H7, and H9 subtypes.

(((~~23~~))) (18) "Institutional review board" ((~~means any board, committee, or other group formally designated by an institution, or authorized under federal or state law, to review, approve the initiation of, or conduct periodic review of research programs to assure the protection of the rights and welfare of human research subjects~~)) has the same meaning as defined in RCW 70.02.010.

(((~~24~~))) (19) "Isolation" means the separation ((~~or restriction of activities of infected individuals, or of persons suspected to be infected, from other persons to prevent transmission of the infectious agent~~)) of infected or contaminated persons or animals from others to prevent or limit the transmission of the infectious agent or contaminant from those infected or contaminated to those who are susceptible to disease or who may spread the infectious agent or contaminant to others.

(((~~25~~))) (20) "Laboratory" means any facility licensed as a test site or medical test site under chapter 70.42 RCW and chapter 246-338 WAC, including any laboratory that is granted a Clinical Laboratory Improvement Amendment (CLIA)-Waiver.

(((~~26~~))) (21) "Laboratory director" means the ((~~director or manager,~~)) person, or person's designee, by whatever title known, having the administrative responsibility ((~~in any licensed medical test site~~)) for a laboratory.

(((~~27~~))) (22) "Local health ((~~department" means the city, town, county, or district agency providing public health services to persons within the area, established under chapters 70.05, 70.08, and 70.46 RCW~~)) jurisdiction" or "LHJ" means a county health department under chapter 70.05 RCW, city-county health department under chapter 70.08 RCW, or health district under chapter 70.46 RCW.

(((~~28~~))) (23) "Local health officer" means the ((~~individual having been appointed under chapter 70.05 RCW as the health officer for the local health department, or having been appointed under chapter 70.08 RCW as the director of public health of a combined city-county health department.~~

~~(29) "Member of the general public" means any person present within the boundary of the state of Washington.~~

~~(30) "Monthly notifiable condition" means a notifiable condition which must be reported to the local health officer or the department within one month of diagnosis.~~

~~(31)~~)) legally qualified physician who has been appointed as the health officer for the local health jurisdiction under chapter 70.05 RCW, or their designee.

(24) "MERS" means Middle East respiratory syndrome.

(25) "Noninfectious condition" means a disease or health concern caused by nonpathogenic factors.

(26) "Notifiable condition" means a ((~~disease or~~)) condition ((~~of public health importance~~)) identified in Table HC-1 of WAC 246-101-101, Table Lab-1 of WAC 246-101-201, and Table Agriculture-1 of WAC 246-101-805, or designated by the local health officer as notifiable under chapter 70.05 RCW, a case of which((~~, and for certain diseases, a suspected case of which, must be brought to the attention of the local health officer or the state health officer.~~

~~(32) "Other rare diseases of public health significance" means a disease or condition, of general or international public health concern, which is occasionally or not ordinarily seen in the state of Washington including, but not limited to, spotted fever rickettsiosis, babesiosis, tick paralysis, anaplasmosis, and other tick borne diseases. This also includes public health events of international concern and communicable diseases that would be of general public concern if detected in Washington.~~

~~(33)~~)) requires notification to public health authorities under this chapter; or a condition designated by the local health officer as notifiable under chapter 70.05 RCW. Notifiable condition does not include provisional conditions as defined under WAC 246-101-015.

(27) "Outbreak" means the occurrence ((~~of cases or suspected cases~~)) of a ((~~disease or~~)) condition in ((~~any~~)) an area over a given period of time in excess of the expected number of ((~~cases~~)) occurrences including, but not limited to, foodborne disease, waterborne disease, and health care-associated infection.

(((~~34) "Patient" means a case, suspected case, or contact.~~

((~~(35)~~)) (28) "Pesticide poisoning" means the disturbance of function, damage to structure, or illness in humans resulting from the inhalation, absorption, ingestion of, or contact with any pesticide.

(((~~(36)~~)) (29) "Presumptive" means a preliminary test result that has not yet been confirmed as a definitive result.

(30) "Principal health care provider" means the attending health care provider recognized as primarily responsible for diagnosis or treatment of a patient, or in the absence of such, the health care provider initiating diagnostic testing or treatment for the patient.

(((~~(37)~~)) (31) "Provisional condition" means a condition the department has requested be reported under WAC 246-101-105.

(32) "Public health authorities" ((~~means~~)) includes local health ((~~departments~~)) jurisdictions, the ((~~state health~~)) department, ((~~and~~)) the department of labor and industries ((~~personnel charged with administering provisions of this chapter.~~

~~(38)~~)), the department of agriculture, sovereign tribal nations, and tribal epidemiology centers.

(33) "Quarantine" means the ((~~separation or restriction on activities of an individual having been exposed to or infected with an infectious agent, to prevent disease transmission.~~

~~(39)~~))) limitation of freedom of movement of persons or domestic animals that have been exposed to, or are suspected to have been exposed to, an infectious agent:

(a) For a period of time not longer than the longest usual incubation period of the infectious agent; and

(b) In a way to prevent effective contact with those not exposed.

(34) "Rapid screening test" or "RST" means a U.S. Food and Drug Administration-approved test that provides same day results and is suitable for obtaining presumptive test results. RST includes point-of-care testing.

(35) "Reference laboratory" means a laboratory licensed inside or outside of Washington state that receives a specimen from another licensed laboratory and performs one or more tests on that specimen.

(36) "School" ((~~means a facility for programs of education as defined~~)) has the same meaning as in RCW 28A.210.-070 (((~~preschool and kindergarten through grade twelve~~))).

(((~~(40)~~))) (37) "SARS" means severe acute respiratory syndrome.

(38) "Secretary" means the secretary of the Washington state department of health.

(39) "Secure electronic data transmission" means electronic communication and accounts developed and maintained to prevent unauthorized access, loss, or compromise of sensitive information including, but not limited to, secure file transfer, secure email, secure facsimile, a health information exchange authorized under RCW 41.05.039, and secure electronic disease surveillance system.

(40) "Secure electronic disease surveillance system" means the secure electronic data transmission system maintained by the department and used by local health jurisdictions to submit notifications, case reports, and outbreak reports under this chapter.

(41) "Sexually transmitted disease (((~~(STD)~~)))" or "sexually transmitted infection" means a bacterial, viral, fungal, or parasitic disease or condition which is usually transmitted through sexual contact, including:

(a) Acute pelvic inflammatory disease;

(b) Chancroid;

(c) *Chlamydia trachomatis* infection;

(d) Genital and neonatal Herpes simplex;

(e) Genital human papilloma virus infection;

(f) Gonorrhea;

(g) Granuloma inguinale;

(h) Hepatitis B infection;

(i) Human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS);

(j) Lymphogranuloma venereum;

(k) Nongonococcal urethritis (NGU); and

(l) Syphilis.

(((~~(41)~~))) (42) "Specimen" means material associated or suspected to be associated with a notifiable condition including, but not limited to, isolates, blood, serum, stool, urine, tissue, respiratory secretions, swab, other body fluid, or an environmental sample.

(43) "State health officer" means the person ((~~designated~~)) appointed by the secretary ((~~of the department~~)) under RCW 43.70.020 to serve as statewide health officer((~~, or, in the absence of this designation, the person having primary responsibility for public health matters in the state.~~

~~(42) "Suspected case" means a person whose diagnosis is thought likely to be a particular disease or condition with suspected diagnosis based on signs and symptoms, laboratory evidence, or both.~~

~~(43) "Third party payor" means an insurer regulated under Title 48 RCW authorized to transact business in this state or other jurisdiction including a health care service contractor and health maintenance organization, an employee welfare benefit plan, or a state or federal health benefit program as defined in RCW 70.02.010.~~

~~(44) "Unexplained critical illness or death" means cases of illness or death with infectious hallmarks but no known etiology, in previously healthy persons one to forty-nine years of age excluding those with chronic medical conditions (e.g., malignancy, diabetes, AIDS, cirrhosis)~~))).

(((~~(45)~~))) (44) "Veterinarian" means an individual licensed and practicing under provisions of chapter 18.92 RCW((~~, Veterinary medicine, surgery, and dentistry~~)).

(45) "Zoonotic disease" means an infectious condition of animals that can cause disease when transmitted to humans.

AMENDATORY SECTION (Amending WSR 11-02-065, filed 1/4/11, effective 2/4/11)

WAC 246-101-015 Provisional ((~~condition~~)) notification and submission of specimen. ((~~This section describes how conditions can become notifiable; what period of time conditions are provisionally notifiable; what analyses must be accomplished during provisional notification status; the transition from provisionally notifiable condition to permanently notifiable condition or deletion of notification requirements. The department's goal for provisionally notifiable~~

~~conditions is to collect enough information to determine whether requiring notification improves public health.~~

~~(1) The state health officer may:~~

~~(a) Request reporting of cases and suspected cases of disease and conditions in addition to those required in Tables HC-1 of WAC 246-101-101, Lab-1 of WAC 246-101-201, and HF-1 of WAC 246-101-301 on a provisional basis for a period of time less than forty-eight months when:~~

~~(i) The disease or condition is newly recognized or recently acknowledged as a public health concern;~~

~~(ii) Epidemiological investigation based on notification of cases may contribute to understanding of the disease or condition;~~

~~(iii) There is reason to expect that the information acquired through notification will assist the state and/or local health department to design or implement intervention strategies that will result in an improvement in public health; and~~

~~(iv) Written notification is provided to all local health officers regarding:~~

~~(A) Additional reporting requirements; and~~

~~(B) Rationale or justification for specifying the disease or condition as notifiable.~~

~~(b) Request laboratories to submit specimens indicative of infections in addition to those required in Table Lab-1 of WAC 246-101-201 on a provisional basis for a period of time less than forty-eight months, if:~~

~~(i) The infection is of public health concern;~~

~~(ii) The department has a plan for using data gathered from the specimens; and~~

~~(iii) Written notification is provided to all local health officers and all laboratory directors explaining:~~

~~(A) Actions required; and~~

~~(B) Reason for the addition.~~

~~(2) Within forty months of the state health officer's designation of a condition as provisionally notifiable in subsection (1)(a) of this section, or requests for laboratories to submit specimens indicative of infections in subsection (1)(b) of this section, the department will conduct an evaluation for the notification requirement that:~~

~~(a) Estimates the societal cost resulting from the provisionally notifiable condition;~~

~~(i) Determine the prevalence of the provisional notifiable condition; and~~

~~(ii) Identify the quantifiable costs resulting from the provisionally notifiable condition; and~~

~~(iii) Discuss the qualitative costs resulting from the provisionally notifiable condition.~~

~~(b) Describes how the information was used and how it will continue to be used to design and implement intervention strategies aimed at combating the provisionally notifiable condition;~~

~~(c) Verifies the effectiveness of previous intervention strategies at reducing the incidence, morbidity, or mortality of the provisional notifiable condition;~~

~~(d) Identifies the quantitative and qualitative costs of the provisional notification requirement;~~

~~(e) Compares the costs of the provisional notification requirement with the estimated cost savings resulting from the intervention based on the information provided through the provisional notification requirement;~~

~~(f) Describes the effectiveness and utility of using the notifiable conditions process as a mechanism to collect these data; and~~

~~(g) Describes that a less burdensome data collection system (example: Biennial surveys) would not provide the information needed to effectively establish and maintain the intervention strategies.~~

~~(3) Based upon the evaluation in subsection (2) of this section, the board will assess results of the evaluation after the particular condition is notifiable or the requirement for laboratories to submit specimens indicative of infections has been in place for no longer than forty months. The board will determine based upon the results of the evaluation whether the provisionally notifiable condition or the requirement for laboratories to submit specimens indicative of infections should be:~~

~~(a) Permanently notifiable in the same manner as the provisional notification requirement;~~

~~(b) Permanently notifiable in a manner that would use the evaluation results to redesign the notification requirements; or~~

~~(c) Deleted from the notifiable conditions system.~~

~~(4) The department shall have the authority to declare an emergency and institute notification requirements under the provisions of RCW 34.05.350.~~)) (1) The state health officer may request additional notification, submission of laboratory test results, or submission of specimens for notifiable conditions.

(2) The state health officer may request notification, submission of laboratory test results, and submission of specimens for a condition they determine should be provisionally reported.

(3) The state health officer may request information under subsection (1) of this section when they:

(a) Determine additional information in case reports or additional submission of specimens for a notifiable condition is needed in order to properly prevent and control the condition; and

(b) Determine that provisional notification or submission of laboratory test results or specimens for a condition other than a notifiable condition is likely to contribute to understanding the condition, provide information necessary to prevent and control the condition, and improve public health.

(4) The state health officer shall notify the board, local health officers, health care providers, laboratory directors, health care facilities, and the department of agriculture of the request, as applicable. The notification must include the:

(a) Determination required under subsection (3) of this section including documentation supporting the determination; and

(b) As applicable, the requested:

(i) Test results;

(ii) Timeline for notification;

(iii) Public health authority to be notified;

(iv) Content of notification;

(v) Means of notification;

(vi) Specimen submission;

(vii) Timeline for specimen submission; and

(viii) Specimen submittal documentation for the condition.

(5) Within forty months of the state health officer's designation of a provisional condition or additional information for a notifiable condition, the state health officer shall:

(a) Discontinue notification, submission of laboratory test results, or submission of specimens for the condition; or

(b) Request that the board consider revising this chapter to require notification, submission of laboratory tests, and submission of specimens for the condition and provide an estimate of the probable benefits and probable costs.

(6) If the state health officer chooses to discontinue notification, submission of laboratory test results, or submission of specimens for the condition, the state health officer shall notify the board, local health officers, health care providers, laboratory directors, health care facilities, and the department of agriculture that the applicable provisional condition or requested changes to the notifiable condition has been discontinued.

(7) If the board directs the state health officer to discontinue notification, submission of laboratory test results, or submission of specimens for the condition, the state health officer shall notify local health officers, health care providers, laboratory directors, health care facilities, and the department of agriculture that the applicable provisional condition or requested changes to the notifiable condition has been discontinued.

PART II: NOTIFIABLE CONDITIONS—HEALTH CARE PROVIDERS AND HEALTH CARE FACILITIES

AMENDATORY SECTION (Amending WSR 11-02-065, filed 1/4/11, effective 2/4/11)

WAC 246-101-101 Notifiable conditions ((~~and the~~))—Health care providers and health care facilities. ((~~This section describes the conditions that Washington's health care providers must notify public health authorities of on a statewide basis. The board finds that the conditions in Table HC-1 of this section are notifiable for the prevention and control of communicable and noninfectious diseases and conditions in Washington.~~

~~(1) Principal health care providers shall notify public health authorities of the conditions identified in Table HC-1 of this section as individual case reports following the requirements in WAC 246-101-105, 246-101-110, 246-101-115, and 246-101-120.~~

~~(2) Other health care providers in attendance, other than the principal health care provider, shall notify public health authorities of the conditions identified in Table HC-1 of this section unless the condition notification has already been made.~~

~~(3) Local health officers may require additional conditions to be notifiable within the local health officer's jurisdiction.~~

~~Table HC-1 (Conditions Notifiable by Health Care Providers)~~

~~Notifiable Condition~~	~~Time Frame for Notification~~	~~Notifiable to Local Health Department~~	~~Notifiable to State Department of Health~~
~~Acquired Immunodeficiency Syndrome (AIDS)~~	~~Within 3 business days~~	~~√~~	
~~Animal Bites (when human exposure to rabies is suspected)~~	~~Immediately~~	~~√~~	
~~Anthrax~~	~~Immediately~~	~~√~~	
~~Arboviral Disease (acute disease only including, but not limited to, West Nile virus, eastern and western equine encephalitis, dengue, St. Louis encephalitis, La Crosse encephalitis, Japanese encephalitis, and Powassan)~~	~~Within 3 business days~~	~~√~~	
~~Asthma, occupational~~	~~Monthly~~		~~√~~
~~Birth Defects - Autism Spectrum Disorders~~	~~Monthly~~		~~√~~
~~Birth Defects - Cerebral Palsy~~	~~Monthly~~		~~√~~
~~Birth Defects - Alcohol Related Birth Defects~~	~~Monthly~~		~~√~~
~~Botulism (foodborne, infant, and wound)~~	~~Immediately~~	~~√~~	
~~Brucellosis (*Brucella* species)~~	~~Within 24 hours~~	~~√~~	
~~*Burkholderia mallei* (Glanders) and *pseudomallei* (Melioidosis)~~	~~Immediately~~	~~√~~	
~~Campylobacteriosis~~	~~Within 3 business days~~	~~√~~	
~~Chancroid~~	~~Within 3 business days~~	~~√~~	
~~*Chlamydia trachomatis* infection~~	~~Within 3 business days~~	~~√~~	
~~Cholera~~	~~Immediately~~	~~√~~	

Notifiable Condition	Time Frame for Notification	Notifiable to Local Health Department	Notifiable to State Department of Health
Cryptosporidiosis	Within 3 business days	√	
Cyclosporiasis	Within 3 business days	√	
Diphtheria	Immediately	√	
Disease of suspected bioterrorism origin	Immediately	√	
Domoic acid poisoning	Immediately	√	
E. coli - Refer to "Shiga toxin-producing *E. coli*"	Immediately	√	
Emerging condition with outbreak potential	Immediately	√	
Giardiasis	Within 3 business days	√	
Gonorrhea	Within 3 business days	√	
Granuloma inguinale	Within 3 business days	√	
Haemophilus influenzae (invasive disease, children under age 5)	Immediately	√	
Hantavirus pulmonary syndrome	Within 24 hours	√	
Hepatitis A (acute infection)	Within 24 hours	√	
Hepatitis B (acute infection)	Within 24 hours	√	
Hepatitis B surface antigen + pregnant women	Within 3 business days	√	
Hepatitis B (chronic infection) - Initial diagnosis, and previously unreported prevalent cases	Monthly	√	
Hepatitis C (acute infection)	Within 3 business days	√	
Hepatitis C (chronic infection)	Monthly	√	
Hepatitis D (acute and chronic infection)	Within 3 business days	√	
Hepatitis E (acute infection)	Within 24 hours	√	
Herpes simplex, neonatal and genital (initial infection only)	Within 3 business days	√	
Human immunodeficiency virus (HIV) infection	Within 3 business days	√	
Influenza, novel or unsubtypable strain	Immediately	√	
Influenza-associated death (lab confirmed)	Within 3 business days	√	
Legionellosis	Within 24 hours	√	
Leptospirosis	Within 24 hours	√	
Listeriosis	Within 24 hours	√	
Lyme Disease	Within 3 business days	√	
Lymphogranuloma venereum	Within 3 business days	√	
Malaria	Within 3 business days	√	
Measles (rubeola) - Acute disease only	Immediately	√	
Meningococcal disease (invasive)	Immediately	√	
Monkeypox	Immediately	√	
Mumps (acute disease only)	Within 24 hours	√	
Outbreaks of suspected foodborne origin	Immediately	√	
Outbreaks of suspected waterborne origin	Immediately	√	
Paralytic shellfish poisoning	Immediately	√	
Pertussis	Within 24 hours	√	
Pesticide poisoning (hospitalized, fatal, or cluster)	Immediately		√
Pesticide poisoning (all other)	Within 3 business days		√

~~Notifiable Condition~~	~~Time Frame for Notification~~	~~Notifiable to Local Health Department~~	~~Notifiable to State Department of Health~~
~~Plague~~	~~Immediately~~	~~√~~	
~~Poliomyelitis~~	~~Immediately~~	~~√~~	
~~Prion disease~~	~~Within 3 business days~~	~~√~~	
~~Psittacosis~~	~~Within 24 hours~~	~~√~~	
~~Q Fever~~	~~Within 24 hours~~	~~√~~	
~~Rabies (Confirmed Human or Animal)~~	~~Immediately~~	~~√~~	
~~Rabies, suspected human exposure (suspected human rabies exposures due to a bite from or other exposure to an animal that is suspected of being infected with rabies)~~	~~Immediately~~	~~√~~	
~~Relapsing fever (borreliosis)~~	~~Within 24 hours~~	~~√~~	
~~Rubella (including congenital rubella syndrome) (acute disease only)~~	~~Immediately~~	~~√~~	
~~Salmonellosis~~	~~Within 24 hours~~	~~√~~	
~~SARS~~	~~Immediately~~	~~√~~	
~~Serious adverse reactions to immunizations~~	~~Within 3 business days~~	~~√~~	
~~Shiga toxin-producing *E. coli* infections (enterohemorrhagic *E. coli* including, but not limited to, *E. coli* O157:H7)~~	~~Immediately~~	~~√~~	
~~Shigellosis~~	~~Within 24 hours~~	~~√~~	
~~Smallpox~~	~~Immediately~~	~~√~~	
~~Syphilis~~	~~Within 3 business days~~	~~√~~	
~~Tetanus~~	~~Within 3 business days~~	~~√~~	
~~Trichinosis~~	~~Within 3 business days~~	~~√~~	
~~Tuberculosis~~	~~Immediately~~	~~√~~	
~~Tularemia~~	~~Immediately~~	~~√~~	
~~Vaccinia transmission~~	~~Immediately~~	~~√~~	
~~Vancomycin-resistant *Staphylococcus aureus* (not to include vancomycin-intermediate)~~	~~Within 24 hours~~	~~√~~	
~~Varicella-associated death~~	~~Within 3 business days~~	~~√~~	
~~Vibriosis~~	~~Within 24 hours~~	~~√~~	
~~Viral hemorrhagic fever~~	~~Immediately~~	~~√~~	
~~Yellow fever~~	~~Immediately~~	~~√~~	
~~Yersiniosis~~	~~Within 24 hours~~	~~√~~	
~~Other rare diseases of public health significance~~	~~Within 24 hours~~	~~√~~	
~~Unexplained critical illness or death~~	~~Within 24 hours~~	~~√~~	

~~(√) Indicates which agency should receive case and suspected case reports.~~))

(1) For the purposes of this section:

(a) "Local health jurisdiction" means where the patient resides, or, in the event the patient residence cannot be determined, the local health jurisdiction in which the patient received treatment.

(b) "Unexplained critical illness or death" means a severe illness or death with infectious hallmarks, but no known etiology, in a previously healthy person one to forty-nine years of age excluding those with chronic medical conditions such as malignancy, diabetes, AIDS, or cirrhosis.

(2) The conditions identified in Table HC-1 are notifiable to public health authorities under this table and this chapter.

Table HC-1 (Conditions Notifiable by Health Care Providers and Health Care Facilities)

Notifiable Condition (Agent)	Laboratory Confirmation Required Before Submitting Case Report	Time Frame for Notification from Identification of a Case	Who Must Be Notified	Who Must Report: Health Care Providers (Providers) or Health Care Facilities (Facilities)
Acquired immunodeficiency syndrome (AIDS)		Within 3 business days	DOH (for facilities) and LHJ (for providers)	Both
Amoebic meningitis		Immediately	LHJ	Both
Anaplasmosis		Within 3 business days	LHJ	Both
Anthrax (*Bacillus anthracis* and confirmed *Bacillus cereus* biovar *anthracis* only - Do not report all *Bacillus cereus*)	Yes	Immediately	LHJ	Both
Arboviral disease (acute disease only) including, but not limited to: Chikungunya Dengue Eastern and western equine encephalitis Japanese encephalitis La Crosse encephalitis Powassan virus infection St. Louis encephalitis West Nile virus infection Zika virus infection See also "Yellow fever"		Within 3 business days	LHJ	Both
Asthma, occupational		Within 30 days	Washington state department of labor and industries (L&I)	Both
Babesiosis		Within 3 business days	LHJ	Both
Baylisascariasis		Within 24 hours	LHJ	Both
Birth defects - Abdominal wall defects (inclusive of gastroschisis and omphalocele)		Within 30 days	LHJ	Facilities
Birth defects - Autism spectrum disorders		Within 30 days	DOH	Both
Birth defects - Cerebral palsy		Within 30 days	DOH	Both
Birth defects - Down syndrome		Within 30 days	DOH	Facilities
Birth defects - Alcohol related birth defects		Within 30 days	DOH	Both
Birth defects - Hypospadias		Within 30 days	DOH	Facilities
Birth defects - Limb reductions		Within 30 days	DOH	Facilities
Birth defects - Neural tube defects (inclusive of anencephaly and spina bifida)		Within 30 days	DOH	Facilities

Notifiable Condition (Agent)	Laboratory Confirmation Required Before Submitting Case Report	Time Frame for Notification from Identification of a Case	Who Must Be Notified	Who Must Report: Health Care Providers (Providers) or Health Care Facilities (Facilities)
Birth defects - Oral clefts (inclusive of cleft lip with/without cleft palate)		Within 30 days	DOH	Facilities
Blood lead level RST results *(See WAC 246-101-200)*		Providers and facilities performing blood lead level RST shall report as a laboratory and comply with the requirements of WAC 246-101-201 through 246-101-230.		
Botulism, foodborne, infant, and wound		Immediately	LHJ	Both
Brucellosis		Within 24 hours	LHJ	Both
Campylobacteriosis		Within 3 business days	LHJ	Both
Cancer (*See chapter 246-102 WAC*)				
Candida auris infection or colonization		Within 24 hours	LHJ	Both
Carbapenem-resistant Enterobacteriaceae infections limited to: *Klebsiella* species *E. coli* *Enterobacter* species	Yes	Within 3 business days	LHJ	Both
Chagas disease		Within 3 business days	LHJ	Both
Chancroid		Within 3 business days	LHJ	Both
Chlamydia trachomatis infection	Yes	Within 3 business days	LHJ	Both
Cholera (*Vibrio cholerae* O1 or O139)	Yes	Immediately	LHJ	Both
Coccidioidomycosis		Within 3 business days	LHJ	Both
Coronavirus infection (severe communicable) SARS-associated coronavirus MERS-associated coronavirus Novel coronavirus (COVID-19)	Yes	Immediately	LHJ	Both
Cryptococcus gattii or undifferentiated *Cryptococcus* species (i.e., *Cryptococcus* not identified as C. *neoformans*)	Yes	Within 3 business days	LHJ	Both
Cryptosporidiosis		Within 3 business days	LHJ	Both
Cyclosporiasis		Within 3 business days	LHJ	Both
Cysticercosis		Within 3 business days	LHJ	Both
Diphtheria		Immediately	LHJ	Both
Domoic acid poisoning		Immediately	LHJ	Both

Notifiable Condition (Agent)	Laboratory Confirmation Required Before Submitting Case Report	Time Frame for Notification from Identification of a Case	Who Must Be Notified	Who Must Report: Health Care Providers (Providers) or Health Care Facilities (Facilities)
E. coli (*See "Shiga toxin-producing E. coli"*)				
Echinococcosis		Within 3 business days	LHJ	Both
Ehrlichiosis		Within 3 business days	LHJ	Both
Giardiasis		Within 3 business days	LHJ	Both
Glanders (*Burkholderia mallei*)	Yes	Immediately	LHJ	Both
Gonorrhea		Within 3 business days	LHJ	Both
Granuloma inguinale		Within 3 business days	LHJ	Both
Gunshot wounds (nonfatal)		Within 30 days	DOH	Facilities
Haemophilus influenzae (invasive disease, children under 5 years of age)	Yes	Immediately	LHJ	Both
Hantaviral infection		Within 24 hours	LHJ	Both
Hepatitis A (acute infection)	Yes	Within 24 hours	LHJ	Both
Hepatitis B (acute infection)	Yes	Within 24 hours	LHJ	Both
Hepatitis B, report pregnancy in hepatitis B virus infected patients (including carriers)	Yes	Within 3 business days	LHJ	Both
Hepatitis B (chronic infection) - Initial diagnosis, and previously unreported prevalent cases	Yes	Within 3 business days	LHJ	Both
Hepatitis B (perinatal) - Initial diagnosis, and previously unreported cases	Yes	Within 3 business days	LHJ	Both
Hepatitis C (acute infection)	Yes	Within 24 hours	LHJ	Both
Hepatitis C (acute infection) RTS results *(See WAC 246-101-200)*		Providers and facilities performing hepatitis C (acute infection) RST shall report as a laboratory and comply with the requirements of WAC 246-101-201 through 246-101-230.		
Hepatitis C (chronic infection)	Yes	Within 3 business days	LHJ	Both
Hepatitis C (perinatal) - Initial diagnosis, and previously unreported cases	Yes	Within 24 hours	LHJ	Both
Hepatitis C (chronic infection) RST results *(See WAC 246-101-200)*		Providers and facilities performing hepatitis C (chronic infection) RST shall report as a laboratory and comply with the requirements of WAC 246-101-201 through 246-101-230.		
Hepatitis D (acute and chronic infection)	Yes	Within 24 hours	LHJ	Both
Hepatitis E (acute infection)	Yes	Within 24 hours	LHJ	Both
Herpes simplex, neonatal and genital (initial infection only)		Within 3 business days	LHJ	Providers

Notifiable Condition (Agent)	Laboratory Confirmation Required Before Submitting Case Report	Time Frame for Notification from Identification of a Case	Who Must Be Notified	Who Must Report: Health Care Providers (Providers) or Health Care Facilities (Facilities)
Histoplasmosis		Within 3 business days	LHJ	Both
Human immunodeficiency virus (HIV) infection		Within 3 business days	LHJ	Both
Human immunodeficiency virus (HIV) infection RST results *(See WAC 246-101-200)*		Providers and facilities performing HIV infection RST shall report as a laboratory and comply with the requirements of WAC 246-101-201 through 246-101-230.		
Human prion disease		Within 3 business days	LHJ	Both
Hypersensitivity pneumonitis, occupational		Within 30 days	L&I	Both
Influenza, novel or unsubtypable strain		Immediately	LHJ	Both
Influenza-associated death (laboratory confirmed)		Within 3 business days	LHJ	Both
Legionellosis		Within 24 hours	LHJ	Both
Leptospirosis		Within 24 hours	LHJ	Both
Listeriosis		Within 24 hours	LHJ	Both
Lyme disease		Within 3 business days	LHJ	Both
Lymphogranuloma venereum		Within 3 business days	LHJ	Both
Malaria		Within 3 business days	LHJ	Both
Measles (rubeola) - Acute disease only		Immediately	LHJ	Both
Melioidosis (*Burkholderia pseudomallei)*	Yes	Immediately	LHJ	Both
Meningococcal disease, invasive		Immediately	LHJ	Both
Monkeypox		Immediately	LHJ	Both
Mumps, acute disease only		Within 24 hours	LHJ	Both
Outbreaks and suspected outbreaks		Immediately	LHJ	Both
Paralytic shellfish poisoning		Immediately	LHJ	Both
Pertussis		Within 24 hours	LHJ	Both
Pesticide poisoning (hospitalized, fatal, or cluster)		Immediately	DOH	Both
Pesticide poisoning (all other)		Within 3 business days	DOH	Both
Plague		Immediately	LHJ	Both
Poliomyelitis		Immediately	LHJ	Both

Notifiable Condition (Agent)	Laboratory Confirmation Required Before Submitting Case Report	Time Frame for Notification from Identification of a Case	Who Must Be Notified	Who Must Report: Health Care Providers (Providers) or Health Care Facilities (Facilities)
Pregnancy in patient with hepatitis B virus		See "Hepatitis B, report pregnancy in hepatitis B virus infected patients (including carriers)"		
Psittacosis		Within 24 hours	LHJ	Both
Q fever		Within 24 hours	LHJ	Both
Rabies (confirmed human or animal)		Immediately	LHJ	Both
Rabies, suspected human exposure (suspected human rabies exposures due to a bite from or other exposure to an animal that is suspected of being infected with rabies)		Immediately	LHJ	Both
Relapsing fever (borreliosis)		Within 3 business days	LHJ	Both
Rickettsia infection		Within 3 business days	LHJ	Both
Rubella, acute disease only (including congenital rubella syndrome)		Immediately	LHJ	Both
Salmonellosis		Within 24 hours	LHJ	Both
Serious adverse reactions to immunizations		Within 3 business days	LHJ	Both
Shiga toxin-producing *E. coli* (STEC) infections/enterohemorrhagic *E. coli* infections	Yes	Immediately	LHJ	Both
Shigellosis		Within 24 hours	LHJ	Both
Silicosis		Within 30 days	L&I	Both
Smallpox		Immediately	LHJ	Both
Syphilis		Within 3 business days	LHJ	Both
Taeniasis		Within 3 business days	LHJ	Both
Tetanus		Within 3 business days	LHJ	Both
Tick paralysis		Within 3 business days	LHJ	Both
Trichinosis		Within 3 business days	LHJ	Both
Tuberculosis disease (confirmed or highly suspicious, i.e., initiation of empiric treatment)		Within 24 hours	LHJ	Both
Tularemia		Immediately	LHJ	Both
Typhus		Within 3 business days	LHJ	Both
Vaccinia transmission		Immediately	LHJ	Both

Notifiable Condition (Agent)	Laboratory Confirmation Required Before Submitting Case Report	Time Frame for Notification from Identification of a Case	Who Must Be Notified	Who Must Report: Health Care Providers (Providers) or Health Care Facilities (Facilities)
Vancomycin-resistant *Staphylococcus aureus* (not to include vancomycin-intermediate)	Yes	Within 24 hours	LHJ	Both
Varicella-associated death		Within 3 business days	LHJ	Both
Vibriosis (*Vibrio* species not including *Vibrio cholerae* O1 or O139) *See* Cholera (*Vibrio cholerae* O1 or O139)	Yes	Within 24 hours	LHJ	Both
Viral hemorrhagic fever		Immediately	LHJ	Both
Yellow fever		Immediately	LHJ	Both
Yersiniosis		Within 24 hours	LHJ	Both
Unexplained critical illness or death		Within 24 hours	LHJ	Both

AMENDATORY SECTION (Amending WSR 11-02-065, filed 1/4/11, effective 2/4/11)

WAC 246-101-105 Duties ((~~of the~~))—Health care providers and health care facilities. ((~~Health care providers shall:~~

~~(1) Notify the local health department where the patient resides, or, in the event that patient residence cannot be determined, the local health department in which the health care providers practice, regarding:~~

~~(a) Cases or suspected cases of notifiable conditions specified as notifiable to local health departments in Table HC-1 of WAC 246-101-101;~~

~~(b) Cases of conditions designated as notifiable by the local health officer within that health officer's jurisdiction;~~

~~(c) Outbreaks or suspected outbreaks of disease including, but not limited to, suspected or confirmed outbreaks of varicella, influenza, viral meningitis, health care-associated infection suspected due to contaminated food products or devices, or environmentally related disease;~~

~~(d) Known barriers which might impede or prevent compliance with orders for infection control or quarantine; and~~

~~(e) Name, address, and other pertinent information for any case, suspected case or carrier refusing to comply with prescribed infection control measures.~~

~~(2) Notify the department of conditions designated as notifiable to the local health department when:~~

~~(a) A local health department is closed or representatives of the local health department are unavailable at the time a case or suspected case of an immediately notifiable condition occurs;~~

~~(b) A local health department is closed or representatives of the local health department are unavailable at the time an outbreak or suspected outbreak of communicable disease occurs.~~

~~(3) Notify the department of pesticide poisoning that is fatal, causes hospitalization or occurs in a cluster.~~

~~(4) Notify the department regarding cases of notifiable conditions specified as notifiable to the department in Table HC-1 of WAC 246-101-101.~~

~~(5) Assure that positive preliminary test results and positive final test results for notifiable conditions of specimens referred to laboratories outside of Washington for testing are correctly notified to the local health department of the patient's residence or the department as specified in Table Lab-1 of WAC 246-101-201. This requirement can be satisfied by:~~

~~(a) Arranging for the referral laboratory to notify either the local health department, the department, or both; or~~

~~(b) Forwarding the notification of~~)) (1) Unless a health care facility has assumed the notification duties of the principal health care provider under subsection (4) of this section, the principal health care provider shall submit individual case reports:

(a) To the required public health authority under Table HC-1 of WAC 246-101-101 and the requirements of WAC 246-101-110 and 246-101-115, and this section;

(b) To the local health jurisdiction as required by the local health officer within that health officer's jurisdiction.

(2) A health care facility shall submit individual case reports:

(a) To the required public health authority under Table HC-1 of WAC 246-101-101 and the requirements of WAC 246-101-110 and 246-101-115, and this section that occur or are treated in their facilities.

(b) To the local health jurisdiction as required by the local health officer within that health officer's jurisdiction.

(3) This section does not require a health care provider or a health care facility to confirm the absence of cases of conditions listed in Table HC-1 of WAC 246-101-101.

(4) A health care facility may assume the notification requirements established in this chapter for a health care provider practicing within the health care facility.

(5) A health care facility shall not assume the notification requirements established in this chapter for a laboratory that is a component of the health care facility.

(6) Health care providers and health care facilities shall:

(a) Provide the laboratory with the following information for each test ordered for a notifiable condition:

(i) Patient's first and last name;

(ii) Patient's physical address including zip code;

(iii) Patient's date of birth;

(iv) Patient's sex;

(v) Patient's race;

(vi) Patient's ethnicity;

(vii) For hepatitis B tests only, pregnancy status (pregnant/not pregnant/unknown) of patients twelve to fifty years of age only;

(viii) Patient's best contact telephone number;

(ix) Patient's medicaid status, for blood lead level tests for patients less than seventy-two months of age only;

(x) Requesting health care provider's name;

(xi) Requesting health care provider's phone number;

(xii) Address where patient received care;

(xiii) Specimen type;

(xiv) Specimen collection date; and

(xv) Condition being tested for.

(b) For specimens associated with a notifiable condition sent to a laboratory outside of Washington state, provide the laboratory with the information under (a) of this subsection, Table Lab-1 of WAC 246-101-201, and WAC 246-101-220 and 246-101-225.

(c) If the presumptive or final test results are consistent with Table Lab-1 of WAC 246-101-201, the health care provider or health care facility shall either:

(i) Confirm the laboratory submitted the case report consistent with WAC 246-101-220 and 246-101-225; or

(ii) Submit the ((~~test result~~)) presumptive and final test results from the ((~~referral~~)) out-of-state laboratory ((~~to the local health department, the department, or both.~~

((~~(6)~~)) with the case report according to the requirements of this chapter.

(d) Cooperate with public health authorities during investigation of:

(((~~(a) Circumstances of a case or suspected~~)) (i) A case of a notifiable condition ((~~or other communicable disease~~)); and

(((~~(b)~~))) (ii) An outbreak or suspected outbreak ((~~of disease~~)).

(((~~(7)~~))) (e) Maintain an infection control program as described in WAC 246-320-176 for hospitals and WAC 246-330-176 for ambulatory surgical facilities;

(f) Provide adequate and understandable instruction in disease control measures to each patient who has been diagnosed with a case of a communicable disease, and to contacts who may have been exposed to the disease((~~.~~

~~(8) Maintain responsibility for deciding date of discharge for hospitalized tuberculosis patients.~~

~~(9) Notify the local health officer of intended discharge of tuberculosis patients in order to assure appropriate outpatient arrangements are arranged.~~

~~(10) By July 1, 2011, when ordering a laboratory test for a notifiable condition as identified in Table HC-1 of WAC 246-101-101, providers must provide the laboratory with the following information for each test order:~~

~~(a) Patient name;~~

~~(b) Patient address including zip code;~~

~~(c) Patient date of birth;~~

~~(d) Patient sex;~~

~~(e) Name of the principal health care provider;~~

~~(f) Telephone number of the principal health care provider;~~

~~(g) Type of test requested;~~

~~(h) Type of specimen;~~

~~(i) Date of ordering specimen collection.~~)); and

(g) Notify the local health jurisdiction of:

(i) Known barriers that might impede or prevent compliance with infection control measures; and

(ii) Name, address, and other pertinent information for any case or carrier refusing to comply with infection control measures.

(7) Health care providers and health care facilities may provide health information, demographic information, or infectious or noninfectious condition information in addition to the information required under this chapter when the provider or facility determines that the additional information will aid the public health authority in protecting and improving the public's health through prevention and control of infectious and noninfectious conditions.

(8) When a health care provider or health care facility submits information under subsection (7) of this section, they shall submit the information under the requirements of WAC 246-101-110.

AMENDATORY SECTION (Amending WSR 11-02-065, filed 1/4/11, effective 2/4/11)

WAC 246-101-110 Means of notification—Health care providers and health care facilities. Health care providers ((~~shall adhere to the following timelines and procedures:~~

~~(1) Conditions designated as immediately notifiable must be reported to the local health officer or the department, as specified in Table HC-1 of WAC 246-101-101, immediately as the time of diagnosis or suspected diagnosis. This applies twenty-four hours a day, seven days a week. Each local health jurisdiction, as well as the department, maintains after-hours emergency phone contacts for this purpose. A party sending a report by secure facsimile copy or secure electronic transmission during normal business hours must confirm immediate receipt by a live person.~~

~~(2) Conditions designated as notifiable within twenty-four hours must be reported to the local health officer or the department, as specified in Table HC-1 of WAC 246-101-101, within twenty-four hours of diagnosis or suspected diagnosis, seven days a week. Reports during normal public health business hours may be sent by secure electronic transmission, telephone, or secure facsimile copy of a case report. A party sending a report outside of normal public health business hours must use the after-hours emergency phone contact for the appropriate jurisdiction.~~

~~(3) Conditions designated as notifiable within three business days must be reported to the local health officer or department, as specified in Table HC-1 of WAC 246-101-101, within three business days. Notification may be sent by written case report, secure electronic transmission, telephone, or secure facsimile copy of a case report; and~~

~~(4) Conditions designated as notifiable on a monthly basis must be reported to the local health officer or the department, as specified in Table HC-1 of WAC 246-101-101, on a monthly basis. Notification may be sent by written case report, secure electronic transmission, telephone, or secure facsimile copy of a case report~~)) and health care facilities shall:

(1) Submit a case report for each case under Table HC-1 of WAC 246-101-101, 246-101-115, and this section by secure electronic data transmission;

(2) Submit a case report to the department instead of the local health jurisdiction when:

(a) The local health jurisdiction is closed or representatives of the local health jurisdiction are unavailable:

(i) For immediately notifiable conditions; or

(ii) At the time an outbreak or suspected outbreak of a communicable disease occurs.

(b) The patient who is the subject of the case report resides outside Washington state and is a visitor to Washington state;

(3) Call the public health authority designated for the condition in Table HC-1 of WAC 246-101-101 immediately and confirm receipt of a case report for conditions designated as:

(a) Immediately notifiable; or

(b) Notifiable within twenty-four hours if the case report is submitted outside of the local health jurisdiction's normal business hours.

AMENDATORY SECTION (Amending WSR 11-02-065, filed 1/4/11, effective 2/4/11)

WAC 246-101-115 Content of ((~~notifications~~)) case reports—Health care providers and health care facilities. (1) ((~~For each condition listed in Table HC-1 of WAC 246-101-101,~~)) Health care providers and health care facilities shall provide the following information ((~~for~~)) in each case ((~~or suspected case~~)) report for a notifiable condition, excluding occupational traumatic injury hospitalizations:

(a) Patient's first and last name;

(b) Patient's physical address including zip code;

(c) ((~~Patient telephone number;~~

~~(d)~~)) Patient's date of birth;

(((~~(e)~~))) (d) Patient's sex;

(e) Patient's race;

(f) Patient's ethnicity;

(g) For hepatitis B acute or chronic infection case reports, pregnancy status (pregnant/not pregnant/unknown) of patients twelve to fifty years of age;

(h) Patient's best contact telephone number;

(i) Name of the principal health care provider;

(j) Telephone number of the principal health care provider;

(k) Address where patient received care;

(l) Name of the person providing the report;

(m) Telephone number of the person providing the report;

(n) Diagnosis or suspected diagnosis of ((~~disease or~~)) the condition; and

(((~~(g)~~))) (o) Pertinent laboratory ((~~data~~)) results, if available((~~;~~

~~(h) Name of the principal health care provider;~~

~~(i) Telephone number of the principal health care provider;~~

~~(j) Address of the principal health care provider;~~

~~(k) Name and telephone number of the person providing the report; and~~

~~(l) Other information as the department may require on forms generated by the department~~)).

(2) The local health officer ((~~or~~)) and the state health officer may ((~~require other~~)) request additional information of epidemiological or public health value when conducting a case investigation or to otherwise prevent and control a specific notifiable condition.

AMENDATORY SECTION (Amending WSR 11-02-065, filed 1/4/11, effective 2/4/11)

WAC 246-101-120 Handling ((~~of case reports and medical~~)) confidential information—Health care providers and health care facilities. (1) All records and specimens ((~~containing~~)) related to a case that contain or are accompanied by patient identifying information are confidential. Patient identifying information includes information that can directly or indirectly identify a patient.

(2) Health care providers, health care facilities, and health care facility personnel shall maintain the confidentiality of patient health care information consistent with chapter 70.02 RCW and any other applicable confidentiality laws.

(3) Health care providers and health care facilities shall:

(a) Establish and implement policies and procedures to maintain confidentiality of health care information under this section, and chapters 70.02 and 70.24 RCW.

(((~~(2) Health care providers who know of a person with a notifiable condition, other than a sexually transmitted disease, shall release identifying information only to other individuals responsible for protecting the health and well-being of the public through control of disease, including the local health department.~~

~~(3) Health care providers with knowledge of a person with sexually transmitted disease, and following the basic principles of health care providers, which respect the human dignity and confidentiality of patients:~~

~~(a) May disclose the identity of a person or release identifying information only as specified in RCW 70.24.105; and~~

~~(b) Shall under RCW 70.24.105(6), use only the following customary methods for exchange of medical information:~~

~~(i) Health care providers may exchange medical information related to HIV testing, HIV test results, and confirmed HIV or confirmed STD diagnosis and treatment in order to provide health care services to the patient. This means that information shared impacts the care or treatment decisions concerning the patient; and the health care provider requires the information for the patient's benefit.~~

~~(ii) Health care providers responsible for office management are authorized to permit access to a patient's medical information and medical record by medical staff or office staff to carry out duties required for care and treatment of a patient and the management of medical information and the patient's medical record.~~

~~(c) Health care providers~~)) (b) When conducting a clinical HIV research project ((~~shall~~)), report the identity of an individual participating in the project unless:

(i) The project has been approved by an institutional review board; and

(ii) The project has a system in place to remind referring health care providers of ((~~their reporting obligations~~)) notification requirements under this chapter.

(((~~4) Health care providers shall establish and implement policies and procedures to maintain confidentiality related to a patient's medical information.~~))

PART III: NOTIFIABLE CONDITIONS—LABORATORIES AND LABORATORY DIRECTORS

NEW SECTION

WAC 246-101-200 Rapid screening testing. An individual or entity including, but not limited to, health care providers and health care facilities, that conduct an RST for any of the following conditions, meets the definition of a laboratory under this chapter, and shall comply with WAC 246-101-201 through 246-101-230:

(1) Blood lead level testing;

(2) Hepatitis C (acute infection);

(3) Hepatitis C (chronic infection); or

(4) HIV infection.

AMENDATORY SECTION (Amending WSR 11-02-065, filed 1/4/11, effective 2/4/11)

WAC 246-101-201 Notifiable conditions ((~~and~~))—Laboratories. ((~~This section describes the conditions about which Washington's laboratories must notify public health authorities of on a statewide basis. The board finds that the conditions in Table Lab-1 of this section are notifiable for the prevention and control of communicable and noninfectious diseases and conditions in Washington. The board also finds that submission of specimens for many of these conditions will further prevent the spread of disease.~~

~~(1) Laboratory directors shall notify public health authorities of positive preliminary test results and positive final test results of the conditions identified in Table Lab-1 of this section as individual case reports and provide specimen submissions following the requirements in WAC 246-101-205, 246-101-210, 246-101-215, 246-101-220, 246-101-225, and 246-101-230.~~

~~(2) Local health officers may require additional conditions to be notifiable within the local health officer's jurisdiction.~~

~~Table Lab-1 (Conditions Notifiable by Laboratory Directors)~~

~~Notifiable Condition~~	~~Time Frame for Notification~~	~~Notifiable to Local Health Department~~	~~Notifiable to Department of Health~~	~~Specimen Submission to Department of Health (Type & Timing)~~
~~Arboviruses (West Nile virus, eastern and western equine encephalitis, dengue, St. Louis encephalitis, La Crosse encephalitis, Japanese encephalitis, Powassan, California serogroup, Chikungunya)~~ ~~Acute:~~ ~~IgM positivity~~ ~~PCR positivity~~ ~~Viral isolation~~	~~2 business days~~	~~√~~		~~On request~~
~~*Bacillus anthracis* (Anthrax)~~	~~Immediately~~	~~√~~		~~Culture (2 business days)~~
~~Blood Lead Level~~	~~Elevated Levels - 2 business days~~ ~~Nonelevated Levels - Monthly~~		~~√~~	
~~*Bordetella pertussis* (Pertussis)~~	~~Within 24 hours~~	~~√~~		~~Culture, when available (2 business days)~~
~~*Borrelia burgdorferi* (Lyme disease)~~	~~2 business days~~	~~√~~		~~On request~~

Notifiable Condition	Time Frame for Notification	Notifiable to Local Health Department	Notifiable to Department of Health	Specimen Submission to Department of Health (Type & Timing)
Borrelia hermsii or *recurrentis* (Relapsing fever, tick- or louse-borne)	Within 24 hours	√		On request
Brucella species (Brucellosis)	Within 24 hours	√		Cultures (2 business days)
Burkholderia mallei and *pseudomallei*	Immediately	√		Culture (2 business days); additional specimens when available
Campylobacter species (Campylobacteriosis)	2 business days	√		On request
CD4 + (T4) lymphocyte counts and/or CD4 + (T4) (patients aged thirteen or older)	Monthly	Only when the local health department is designated by the Department of Health	√ (Except King County)	
Chlamydophila psittaci (Psittacosis)	Within 24 hours	√		On request
Chlamydia trachomatis	2 business days	√		
Clostridium botulinum (Botulism)	Immediately	√		Serum and/or stool; any other specimens available (i.e., foods submitted for suspected foodborne case; debrided tissue submitted for suspected wound botulism) (2 business days)
Corynebacterium diphtheriae (Diphtheria)	Immediately	√		Culture (2 business days)
Coxiella burnetii (Q fever)	Within 24 hours	√		Culture (2 business days)
Cryptococcus non *v. neoformans*	N/A	N/A		Culture (2 business days) or other specimens upon request
Cryptosporidium (Cryptosporidiosis)	2 business days	√		On request
Cyclospora cayetanensis (Cyclosporiasis)	2 business days	√		Specimen (2 business days)
E. coli - Refer to "Shiga toxin-producing *E. coli*"	Immediately	√		
Francisella tularensis (Tularemia)	Immediately	√		Culture or other appropriate clinical material (2 business days)
Giardia lamblia (Giardiasis)	2 business days	√		On request
Haemophilus influenzae (children < 5 years of age)	Immediately	√		Culture, from sterile sites only, when type is unknown (2 business days)

Notifiable Condition	Time Frame for Notification	Notifiable to Local Health Department	Notifiable to Department of Health	Specimen Submission to Department of Health (Type & Timing)
Hantavirus	Within 24 hours	√		On request
Hepatitis A virus (acute) by IgM positivity (Hepatocellular enzyme levels to accompany report)	Within 24 hours	√		On request
Hepatitis B virus (acute) by IgM positivity	Within 24 hours	√		On request
Hepatitis B virus - HBsAg (Surface antigen) - HBeAg (E antigen) - HBV DNA	Monthly	√		
Hepatitis C virus	Monthly	√		
Hepatitis D virus	2 business days	√		On request
Hepatitis E virus	Within 24 hours	√		On request
Human immunodeficiency virus (HIV) infection (for example, positive Western Blot assays, P24 antigen or viral culture tests)	2 business days	Only when the local health department is designated by the Department of Health	√ (Except King County)	
Human immunodeficiency virus (HIV) infection (ll viral load detection test results - detectable and undetectable)	Monthly	Only when the local health department is designated by the Department of Health	√ (Except King County)	
Influenza virus, novel or unsubtypable strain	Immediately	√		Isolate or clinical specimen (2 business days)
Legionella species (Legionellosis)	Within 24 hours	√		Culture (2 business days)
Leptospira species (Leptospirosis)	Within 24 hours	√		On request
Listeria monocytogenes (Listeriosis)	Within 24 hours	√		Culture (2 business days)
Measles virus (rubeola) Acute: IgM positivity PCR positivity	Immediately	√		Isolate or clinical specimen associated with positive result (2 business days)
Mumps virus Acute: IgM positivity PCR positivity	Within 24 hours	√		Isolate or clinical specimen associated with positive result (2 business days)
Mycobacterium tuberculosis (Tuberculosis)	2 business days		√	Culture (2 business days)
Mycobacterium tuberculosis (Tuberculosis) (Antibiotic sensitivity for first isolates)	2 business days		√	
Neisseria gonorrhoeae (Gonorrhea)	2 business days	√		

Notifiable Condition	Time Frame for Notification	Notifiable to Local Health Department	Notifiable to Department of Health	Specimen Submission to Department of Health (Type & Timing)
Neisseria meningitidis (Meningococcal disease)	Immediately	√		Culture (from sterile sites only) (2 business days)
Plasmodium species (Malaria)	2 business days	√		On request
Poliovirus Acute: IgM positivity PCR positivity	Immediately	√		Isolate or clinical specimen associated with positive result (2 business days)
Rabies virus (human or animal)	Immediately	√ (Pathology Report Only)		Clinical specimen associated with positive result (2 business days)
Salmonella species (Salmonellosis)	Within 24 hours	√		Culture (2 business days)
SARS-associated coronavirus	Immediately	√		Isolate or clinical specimen associated with positive result (2 business days)
Shiga toxin-producing *E. coli* (enterohemorrhagic *E. coli* including, but not limited to, *E. coli* O157:H7)	Immediately	√		Culture (2 business days) or specimen if no culture is available
Shigella species (Shigellosis)	Within 24 hours	√		Culture (2 business days)
Treponema pallidum (Syphilis)	2 business days	√		Serum (2 business days)
Trichinella species	2 business days	√		On request
Vancomycin-resistant *Staphylococcus aureus*	Within 24 hours	√		Culture (2 business days)
Variola virus (smallpox)	Immediately	√		Isolate or clinical specimen associated with positive result (2 business days)
Vibrio cholerae O1 or O139 (Cholera)	Immediately	√		Culture (2 business days)
Vibrio species (Vibriosis)	Within 24 hours	√		Culture (2 business days)
Viral hemorrhagic fever: Arenaviruses Bunyaviruses Filoviruses Flaviviruses	Immediately	√		Isolate or clinical specimen associated with positive result (2 business days)
Yellow fever virus	Immediately	√		Serum (2 business days)
Yersinia enterocolitica or *pseudotuberculosis*	Within 24 hours	√		On request

~~Notifiable Condition~~	~~Time Frame for Notification~~	~~Notifiable to Local Health Department~~	~~Notifiable to Department of Health~~	~~Specimen Submission to Department of Health (Type & Timing)~~
~~*Yersinia pestis* (Plague)~~	~~Immediately~~	~~√~~		~~Culture or other appropriate clinical material (2 business days)~~

~~(√) Indicates which agency should receive case and suspected case reports.~~

~~(3) The local health department may request laboratory reporting of additional test results pertinent to an investigation of a notifiable condition (e.g., hepatocellular enzyme levels for hepatitis or negative stool test results on salmonellosis rescreening).~~

~~(4) Laboratory directors may notify the local health department, the department, or both of other laboratory results.~~)) (1) For the purposes of Table Lab-1:

(a) "At least annually" means deidentified negative screening results may be submitted in a single report no less than once per year, but may be submitted more frequently as a single report or as individual screening results.

(b) "Deidentified negative screening result" means an initial test result that indicates the absence of disease, and that has personally identifiable information removed from it using the Health Insurance Portability and Accountability Act of 1996 Safe Harbor method defined in 45 C.F.R. 164.514. A deidentified negative screening result does not include a negative test result associated with a previous positive test result, such as a negative nucleic acid or viral load test that is performed after a positive antibody or antigen test.

(c) "LHJ" means where the patient resides, or, in the event that patient residence cannot be determined, the local health jurisdiction in which the ordering health care provider practices, or the local health jurisdiction in which the laboratory operates.

(d) "Within two business days" means specimens must be in transit to the Washington state public health laboratories within two business days of:

(i) Completing a test and the specimen being ready for packaging; or

(ii) Receiving a request from a local health jurisdiction or the department, provided the specimen is still available at the time of the request.

(2) This chapter does not require a laboratory to:

(a) Test for agents (conditions) or speciate if the laboratory does not perform the test as part of its normal work. A laboratory director shall only report a case of a condition if it is identified as part of their normal testing protocols; or

(b) Retain specimens indefinitely in anticipation of a request from a local health jurisdiction or the department.

(3) The agents (conditions) in Table Lab-1 are notifiable by a laboratory director as indicated in Table Lab-1 and this chapter.

Table Lab-1 (Conditions Notifiable by Laboratory Directors)

	Notification of Results		**Specimen Submission to the Washington State Public Health Laboratories**	
Agent (Condition)	**What to Submit in a Case Report**	**When and Whom to Notify Upon Receiving Presumptive or Final Test Result**	**What to Submit**	**When to Submit**
Amoebic meningitis	Positive result by any method	Immediately to LHJ	Specimen associated with positive result, if available	Within 2 business days
Anaplasma species (Anaplasmosis)	Positive result by any method	Within 2 business days to LHJ	Specimen associated with positive result, if available	Within 2 business days of request by LHJ or DOH
Babesia species (Babesiosis)	Positive result by any method	Within 2 business days to LHJ	Specimen associated with positive result, if available	Within 2 business days of request by LHJ or DOH
Bacillus anthracis (Anthrax)	Positive result by any method	Immediately to LHJ	Presumptive positive isolate If no isolate available, specimen associated with presumptive positive result	Within 2 business days

Agent (Condition)	Notification of Results		Specimen Submission to the Washington State Public Health Laboratories	
	What to Submit in a Case Report	When and Whom to Notify Upon Receiving Presumptive or Final Test Result	What to Submit	When to Submit
Bacillus cereus, biovar *anthracis* only	Confirmed positive result by any method	Immediately to LHJ	Do not ship specimen	Do not ship specimen
Baylisascaris (Baylisascariasis)	Positive result by any method	Within 24 hours to LHJ	Specimen associated with positive result, if available	Within 2 business days
Blood lead level	Elevated results equal to or greater than 5 micrograms per deciliter for: RST Venous	Within 2 business days to DOH	N/A	N/A
	Nonelevated results less than 5 micrograms per deciliter for: RST Venous	Within 30 days to DOH		
Bordetella pertussis (Pertussis)	Positive results by: Culture Nucleic acid detection ((nucleic acid testing (NAT)) or (nucleic acid amplification testing (NAAT))	Within 24 hours to LHJ	Isolate	Within 2 business days
			If no isolate available, specimen associated with positive result	Within 2 business days of request by LHJ or DOH
Borrelia burgdorferi or *Borrelia mayonii* (Lyme disease)	Positive result by any method	Within 2 business days to LHJ	Specimen associated with positive result	Within 2 business days of request by LHJ or DOH
Borrelia hermsii, *parkeri*, *turicatae*, *miyamotoi*, or *recurrentis* (Relapsing fever, tick- or louse-borne)	Positive result by any method	Within 2 business days to LHJ	Specimen associated with positive result	Within 2 business days of request by LHJ or DOH
Brucella species (Brucellosis)	Positive result by any method excluding Immunoglobulin G (IgG)	Within 24 hours to LHJ	Isolate, excluding confirmed positive *B. melitensis, B. abortus,* or *B. suis* If no isolate available, specimen associated with positive result	Within 2 business days
Burkholderia mallei (Glanders)	Positive result by any method excluding IgG	Immediately to LHJ	Presumptive positive isolate If no isolate available, specimen associated with presumptive positive result	Within 2 business days

Agent (Condition)	Notification of Results		Specimen Submission to the Washington State Public Health Laboratories	
	What to Submit in a Case Report	When and Whom to Notify Upon Receiving Presumptive or Final Test Result	What to Submit	When to Submit
Burkholderia pseudomallei (Melioidosis)	Positive result by any method excluding IgG	Immediately to LHJ	Presumptive positive isolate If no isolate available, specimen associated with presumptive positive result	Within 2 business days
California serogroup viruses, acute (Arbovirus)	Positive result by any method excluding IgG	Within 2 business days to LHJ	Specimen associated with positive result	Within 2 business days of request by LHJ or DOH
Campylobacter species (Campylobacteriosis)	Positive result by: Culture Nucleic acid detection (NAT or NAAT) Antigen detection	Within 2 business days to LHJ	Isolate If no isolate available, specimen associated with positive result	Within 2 business days of request by LHJ or DOH
Candida auris	Positive result by any method	Within 24 hours to LHJ	Isolate If no isolate available, specimen associated with positive result	Within 2 business days
Carbapenem-resistant Enterobacteriaceae: *Klebsiella* species *E. coli* *Enterobacter* species	Positive for known carbapenemase resistance gene (including, but not limited to, KPC, NDM, VIM, IMP, OXA-48) demonstrated by nucleic acid detection (NAT or NAAT), or whole genome sequencing Positive on a phenotypic test for carbapenemase production including, but not limited to, Metallo-B-lactamase test, modified Hodge test (MHT) (for *E. coli* and *Klebsiella* species only), CarbaNP, Carbapenem Inactivation Method (CIM) or modified CIM (mCIM)	Within 2 business days to LHJ	Isolate If no isolate available, specimen associated with positive result	Within 2 business days

Agent (Condition)	Notification of Results		Specimen Submission to the Washington State Public Health Laboratories	
	What to Submit in a Case Report	When and Whom to Notify Upon Receiving Presumptive or Final Test Result	What to Submit	When to Submit
	Resistant to any carbapenem including, but not limited to, doripenem, ertapenem, imipenem or meropenem			
CD4 + counts[1], or CD4 + percents[2], or both (patients aged thirteen or older)	All results	Within 30 days to DOH except in King County where this is notifiable to the LHJ	N/A	N/A
Chikungunya virus, acute (Arbovirus)	Positive result by any method excluding Immunoglobulin G (IgG)	Within 2 business days to LHJ	Specimen associated with positive result	Within 2 business days of request by LHJ or DOH
Chlamydia psittaci (Psittacosis)	Positive result by any method excluding IgG	Within 24 hours to LHJ	Specimen associated with positive result	Within 2 business days of request by LHJ or DOH
Chlamydia trachomatis	Positive and indeterminate result by any method	Within 2 business days to LHJ	N/A	N/A
Chlamydia trachomatis	Deidentified negative screening result	At least annually to DOH	N/A	N/A
Clostridium botulinum (Botulism)	Positive result by any method	Immediately to LHJ	Presumptive positive isolate	Within 2 business days
			If no isolate available, specimen associated with presumptive positive result	
Coccidioides (Coccidioidomycosis)	Positive result by any method	Within 2 business days to LHJ	Isolate	Within 2 business days
			If no isolate available, specimen associated with positive result	Within 2 business days of request by LHJ or DOH
Coronavirus SARS-associated coronavirus MERS-associated coronavirus Novel coronavirus (SARS-CoV-2)	Positive result by any method	Immediately to LHJ	Presumptive positive isolate, if no isolate available, specimen associated with presumptive positive result	Within 2 business days of request by LHJ or DOH
Corynebacterium diphtheriae (Diphtheria)	Positive result by: Culture Nucleic acid detection (NAT or NAAT)	Immediately to LHJ	Isolate	Within 2 business days
			If no isolate available, specimen associated with positive result	Within 2 business days of request by LHJ or DOH

Agent (Condition)	Notification of Results		Specimen Submission to the Washington State Public Health Laboratories	
	What to Submit in a Case Report	When and Whom to Notify Upon Receiving Presumptive or Final Test Result	What to Submit	When to Submit
Coxiella burnetii (Q fever)	Positive result by any method	Within 24 hours LHJ	Specimen associated with presumptive positive result	Within 2 business days
Crimean-Congo hemorrhagic fever virus (Viral hemorrhagic fever)	Positive result by any method	Immediately to LHJ	Presumptive positive isolate If no isolate available, specimen associated with presumptive positive result	Within 2 business days
Cryptococcus gattii or undifferentiated *Cryptococcus* species (i.e., *Cryptococcus* not identified as C. *neoformans*)	Positive results by any method excluding cryptococcal antigen	Within 2 business days to LHJ	Isolate If no isolate available, specimen associated with positive result (excluding serum)	Within 2 business days
			Serum	Within 2 business days of request by LHJ or DOH
Cryptosporidium (Cryptosporidiosis)	Positive result by any method	Within 2 business days to LHJ	Specimen associated with positive result	Within 2 business days of request by LHJ or DOH
Cyclospora cayetanensis (Cyclosporiasis)	Positive result by any method	Within 2 business days to LHJ	Specimen associated with positive result	Within 2 business days of request by LHJ or DOH
Dengue virus, acute (Arbovirus)	Positive result by any method excluding IgG	Within 2 business days to LHJ	Specimen associated with positive result	Within 2 business days of request by LHJ or DOH
E. coli - Refer to "Shiga toxin-producing *E. coli*"				
Eastern and western equine encephalitis virus, acute (Arbovirus)	Positive result by any method excluding IgG	Within 2 business days to LHJ	Specimen associated with positive result excluding specimens from viral culture	Within 2 business days of request by LHJ or DOH
Ebola virus (Viral hemorrhagic fever)	Positive result by any method	Immediately to LHJ	Presumptive positive specimen	Within 2 business days
Echinococcus granulosus or *E. multilocularis* (Echinococcosis)	Positive result by any method	Within 2 business days to LHJ	Specimen associated with positive result	Within 2 business days of request by LHJ or DOH
Ehrlichia species (Ehrlichiosis)	Positive result by any method	Within 2 business days to LHJ	Specimen associated with positive result	Within 2 business days of request by LHJ or DOH
Francisella tularensis (Tularemia)	Positive result by any method	Immediately to LHJ	Presumptive positive isolate	Within 2 business days

Agent (Condition)	Notification of Results		Specimen Submission to the Washington State Public Health Laboratories	
	What to Submit in a Case Report	When and Whom to Notify Upon Receiving Presumptive or Final Test Result	What to Submit	When to Submit
			If no isolate available, specimen associated with presumptive positive result	
Giardia duodenalis, G. lamblia, G. intestinalis (Giardiasis)	Positive result by any method	Within 2 business days to LHJ	Specimen associated with positive result	Within 2 business days of request by LHJ or DOH
Guanarito virus (Viral hemorrhagic fever)	Positive result by any method	Immediately to LHJ	Presumptive positive isolate If no isolate available, specimen associated with presumptive positive result	Within 2 business days
Haemophilus influenzae (children < 5 years of age)	Positive result for specimen from a normally sterile site by: Culture Nucleic acid detection (NAT or NAAT)	Immediately to LHJ	Isolate If no isolate available, specimen associated with positive result	Within 2 business days
Hantavirus including, but not limited to: Andes virus Bayou virus Black Creek Canal virus Dobrava-Belgrade virus Hantaan virus Seoul virus Sin nombre virus	Positive result by any method	Within 24 hours to LHJ	Specimen associated with positive result	Within 2 business days
Hepatitis A virus	Positive results for: IgM Nucleic acid detection (NAT or NAAT) Hepatocellular enzyme levels to accompany report, if available, for positive IgM results	Within 24 hours to LHJ	Specimen associated with positive result	Within 2 business days of request by LHJ or DOH

Agent (Condition)	Notification of Results		Specimen Submission to the Washington State Public Health Laboratories	
	What to Submit in a Case Report	When and Whom to Notify Upon Receiving Presumptive or Final Test Result	What to Submit	When to Submit
Hepatitis B virus	Positive results for: IgM anti-HBc HBsAg HBeAg HBV Nucleic acid detection (NAT or NAAT) either qualitative or quantitative, for example PCR or genotyping If associated with a positive result listed above, and available: Hepatocellular enzyme levels Pregnancy status Negative IgM anti-HBc result	Within 24 hours to LHJ	Specimen associated with positive result	Within 2 business days of request by LHJ or DOH
Hepatitis C virus	Positive result by any method Positive and nonpositive results for: HCV nucleic acid detection (NAT or NAAT) for qualitative, quantitative, and genotype tests If associated with a positive result and available: Hepatocellular enzyme levels Pregnancy status Negative result for IgM anti-HAV Negative result for IgM anti-HBc	Within 2 business days to LHJ	Specimen associated with positive result	Within 2 business days of request by LHJ or DOH
Hepatitis C virus	Deidentified negative screening result	At least annually to DOH	N/A	N/A
Hepatitis D virus	Positive result by any method If associated with a positive result and available: Hepatocellular enzyme levels	Within 24 hours to LHJ	Specimen associated with positive result	Within 2 business days of request by LHJ or DOH

Agent (Condition)	Notification of Results		Specimen Submission to the Washington State Public Health Laboratories	
	What to Submit in a Case Report	When and Whom to Notify Upon Receiving Presumptive or Final Test Result	What to Submit	When to Submit
Hepatitis E virus	Positive result by any method If associated with a positive result and available: Hepatocellular enzyme levels	Within 24 hours to LHJ	Specimen associated with positive result	Within 2 business days of request by LHJ or DOH
Histoplasma capsulatum (histoplasmosis)	Positive result by any method	Within 2 business days to LHJ	Isolate	Within 2 business days
			Serum	Within 2 business days of request by LHJ or DOH
Human immunodeficiency virus (HIV)	Positive and indeterminate results and subsequent negative results associated with those positive or indeterminate results for the tests below: Antibody detection tests (including RST) Antigen detection tests (including RST) Viral culture All HIV nucleic acid detection (NAT or NAAT) tests: Qualitative and quantitative Detectable and undetectable HIV antiviral resistance testing genetic sequences	Within 2 business days to DOH except in King County where this is notifiable to the LHJ	N/A	N/A
Human immunodeficiency virus (HIV)	Deidentified negative screening result	At least annually to DOH	N/A	N/A
Human prion disease	Positive result by any method excluding Tau protein	Within 2 business days to LHJ	Specimen associated with positive result	Within 2 business days of request by LHJ or DOH
Influenza virus, novel or unsubtypable strain	Positive novel and unsubtypable result	Immediately to LHJ	Isolate If no isolate available, specimen associated with positive result	Within 2 business days
Japanese encephalitis virus, acute (Arbovirus)	Positive result by any method excluding IgG	Within 2 business days to LHJ	Specimen associated with positive result	Within 2 business days of request by LHJ or DOH

Agent (Condition)	Notification of Results		Specimen Submission to the Washington State Public Health Laboratories	
	What to Submit in a Case Report	When and Whom to Notify Upon Receiving Presumptive or Final Test Result	What to Submit	When to Submit
Junin virus (Viral hemorrhagic fever)	Positive result by any method	Immediately to LHJ	Presumptive positive isolate If no isolate available, specimen associated with presumptive positive result	Within 2 business days
La Crosse encephalitis virus, acute (Arbovirus)	Positive result by any method excluding IgG	Within 2 business days to LHJ	Specimen associated with positive result	Within 2 business days of request by LHJ or DOH
Lassa virus (Viral hemorrhagic fever)	Positive result by any method	Immediately to LHJ	Presumptive positive isolate If no isolate available, specimen associated with presumptive positive result	Within 2 business days
Legionella species (Legionellosis)	Positive result by any method	Within 24 hours to LHJ	Isolate If no isolate available but respiratory specimen available *and* associated with a positive test (as in the case of a PCR positive), respiratory specimen associated with positive result	Within 2 business days
Leptospira species (Leptospirosis)	Positive result by any method	Within 24 hours to LHJ	Isolate If no isolate available, specimen associated with positive result	Within 2 business days of request by LHJ or DOH
Listeria monocytogenes (Listeriosis)	Positive result for specimen from a normally sterile site by: Culture Nucleic acid detection (NAT or NAAT)	Within 24 hours to LHJ	Isolate If no isolate available, specimen associated with positive result	Within 2 business days
Lujo virus (Viral hemorrhagic fever)	Positive result by any method	Immediately to LHJ	Presumptive positive isolate If no isolate available, specimen associated with presumptive positive result	Within 2 business days

Agent (Condition)	Notification of Results		Specimen Submission to the Washington State Public Health Laboratories	
	What to Submit in a Case Report	When and Whom to Notify Upon Receiving Presumptive or Final Test Result	What to Submit	When to Submit
Machupo virus (Viral hemorrhagic fever)	Positive result by any method	Immediately to LHJ	Presumptive positive isolate If no isolate available, specimen associated with presumptive positive result	Within 2 business days
Marburg virus (Viral hemorrhagic fever)	Positive result by any method	Immediately to LHJ	Presumptive positive isolate If no isolate available, specimen associated with presumptive positive result	Within 2 business days
Measles virus - See "Rubeola (measles virus)"				
Mumps virus	Positive result for: Culture Nucleic acid detection (NAT or NAAT) IgM	Within 24 hours to LHJ	Isolate If no isolate available, specimen associated with positive result	Within 2 business days
			Specimen associated with positive IgM	Within 2 business days of request by LHJ or DOH
Mycobacterium tuberculosis complex (Tuberculosis)	Positive result for: Culture Nucleic acid detection (NAT or NAAT) Drug susceptibilities (molecular and culture based)	Within 2 business days to DOH	Mycobacterium tuberculosis complex positive isolate (earliest available isolate for the patient)	Within 2 business days
Neisseria gonorrhoeae (Gonorrhea)	Positive and indeterminate result by any method	Within 2 business days to LHJ	N/A	N/A
Neisseria gonorrhoeae (Gonorrhea)	Deidentified negative screening result	At least annually to DOH	N/A	N/A
Neisseria meningitidis (Meningococcal disease)	Positive result for specimen from a normally sterile site by any method	Immediately to LHJ	Isolate from a normally sterile site	Within 2 business days
			If no isolate available, specimen associated with positive result	Within 2 business days of request by LHJ or DOH

Agent (Condition)	Notification of Results		Specimen Submission to the Washington State Public Health Laboratories	
	What to Submit in a Case Report	When and Whom to Notify Upon Receiving Presumptive or Final Test Result	What to Submit	When to Submit
Plasmodium species (Malaria)	Positive results for: Nucleic acid detection (NAT or NAAT) Malaria-specific antigens by rapid diagnostic test PCR Microscopy (thick or thin smear)	Within 2 business days to LHJ	Specimen associated with positive result	Within 2 business days of request by LHJ or DOH
Poliovirus (Poliomyelitis)	IgM positivity; PCR positivity	Immediately to LHJ	Isolate If no isolate available, specimen associated with positive result	Within 2 business days
Powassan virus, acute (Arbovirus)	Positive result by any method excluding IgG	Within 2 business days to LHJ	Specimen associated with positive result	Within 2 business days of request by LHJ or DOH
Rabies virus	Positive result by any method	Immediately to LHJ	Specimen associated with positive result	Within 2 business days
Rickettsia species including, but not limited to: *Rickettsia rickettsii* *Rickettsia africae* *Rickettsia conorii* *Rickettsia typhi* *Rickettsia parkeri* *Rickettsia philipii*	Positive results by any method	Within 2 business days to LHJ	Specimen associated with positive result	Within 2 business days of request by LHJ or DOH
Rubella	Positive result by: Culture IgM Nucleic acid detection (NAT or NAAT)	Immediately to LHJ	Isolate If no isolate available, specimen associated with positive result	Within 2 business days
			Other specimen	Within 2 business days of request by LHJ or DOH
Rubeola (measles virus)	Positive result by: Culture IgM Nucleic acid detection (NAT or NAAT)	Immediately to LHJ	Isolate and specimen associated with positive culture Isolate and specimen association with positive NAT or NAAT result	Within 2 business days
			Specimen associated with positive IgM Other specimen	Within 2 business days of request by LHJ or DOH

Agent (Condition)	Notification of Results		Specimen Submission to the Washington State Public Health Laboratories	
	What to Submit in a Case Report	When and Whom to Notify Upon Receiving Presumptive or Final Test Result	What to Submit	When to Submit
Sabia virus (Viral hemorrhagic fever)	Positive result by any method	Immediately to LHJ	Presumptive positive isolate If no isolate available, specimen associated with presumptive positive result	Within 2 business days
Salmonella species (Salmonellosis, typhoid fever)	Positive result by any method	Within 24 hours to LHJ	Isolate If no isolate available, specimen associated with positive result	Within 2 business days
Shiga toxin-producing *E. coli*/enterohemorrhagic *E. coli* (STEC)	Positive result by any method	Immediately to LHJ	Isolate If no isolate available, specimen associated with positive result	Within 2 business days
Shigella species (Shigellosis)	Positive result by any method	Within 24 hours to LHJ	Isolate If no isolate available, specimen associated with positive result	Within 2 business days
St. Louis encephalitis virus, acute (Arbovirus)	Positive result by any method excluding IgG	Within 2 business days to LHJ	Specimen associated with positive result	Within 2 business days of request by LHJ or DOH
Taenia solium (Taeniasis or Cysticercosis)	Positive result by any method	Within 2 business days to LHJ	Specimen associated with positive result	Within 2 business days of request by LHJ or DOH
Treponema pallidum (Syphilis)	Positive and indeterminate result by any method	Within 2 business days to LHJ	Specimen associated with positive result	Within 2 business days
Treponema pallidum (Syphilis)	Deidentified negative screening result	At least annually to DOH	N/A	N/A
Trichinella species (Trichinellosis)	Positive serologic test for *Trichinella*	Within 2 business days to LHJ	Specimen associated with positive result	Within 2 business days of request by LHJ or DOH
Trypanosoma cruzi (Chagas disease)	Positive result by any method	Within 2 business days to LHJ	Specimen associated with positive result	Within 2 business days
Vaccinia (vaccine-acquired smallpox)	Any request for testing associated with a suspect case	Immediately to LHJ	Any specimen collected from a suspect case	Immediately
Vancomycin-resistant *Staphylococcus aureus*	Resistance to vancomycin	Within 24 hours to LHJ	Isolate If no isolate available, specimen associated with positive result	Within 2 business days

Agent (Condition)	Notification of Results		Specimen Submission to the Washington State Public Health Laboratories	
	What to Submit in a Case Report	When and Whom to Notify Upon Receiving Presumptive or Final Test Result	What to Submit	When to Submit
Variola virus (smallpox)	Any request for testing associated with a suspect case	Immediately to LHJ	Specimen collected from a suspect case	Immediately
Vibrio cholerae O1 or O139 (Cholera)	Positive result by any method	Immediately to LHJ	Isolate If no isolate available, specimen associated with positive result	Within 2 business days
Vibrio species (Vibriosis) not including *Vibrio cholerae* O1 or O139 (Cholera) See *"Vibrio cholerae* O1 or O139 (Cholera)"	Positive result by any method	Within 24 hours to LHJ	Isolate If no isolate available, specimen associated with positive result	Within 2 business days
West Nile virus, acute (Arbovirus)	Positive result by any method excluding IgG	Within 2 business days to LHJ	Specimen associated with positive result	Within 2 business days of request by LHJ or DOH
Yellow fever virus (Arbovirus)	Positive result by any method excluding IgG	Immediately to LHJ	Specimen associated with positive result	Within 2 business days
Yersinia enterocolitica, Y. pseudotuberculosis, Y. intermedia, Y. fredericksenii, or *Y. kristensenii* (Yersiniosis)	Positive result by any method	Within 24 hours to LHJ	Isolate If no isolate available, specimen associated with positive result	Within 2 business days of request by LHJ or DOH
Yersinia pestis (Plague)	Positive result by any method	Immediately to LHJ	Presumptive positive isolate If no isolate available, specimen associated with presumptive positive result	Within 2 business days
Zika virus, acute (Arbovirus)	Positive result by any method excluding IgG	Within 2 business days to LHJ	Specimen associated with positive result	Within 2 business days of request by LHJ or DOH

[1] "CD4 + counts" means CD4 + (T4) lymphocyte counts.

[2] "CD4 + percents" means CD4 + (T4) percents of total lymphocytes.

AMENDATORY SECTION (Amending WSR 11-02-065, filed 1/4/11, effective 2/4/11)

WAC 246-101-205 ((~~Responsibilities and~~)) Duties ((~~of the~~)) Laboratory director~~s~~. (1) A laboratory director((~~s~~)) shall:

(a) ((~~Notify the local health department where the patient resides, or, in the event that patient residence cannot be determined, the local health department in which the ordering health care provider practices, or the local health department in which the laboratory operates, regarding:~~

~~(i) Positive preliminary test results and positive final test results of notifiable conditions specified as notifiable to the local health department in Table Lab 1.~~

~~(ii) Positive preliminary test results and positive final test results of conditions specified as notifiable by the local health officer within that health officer's jurisdiction.~~)) Submit case reports:

(i) To the local health jurisdiction or the department as required in Table Lab-1 of WAC 246-101-201, and under the requirements of WAC 246-101-220, 246-101-225, and this section; and

(ii) To the local health jurisdiction as required by the local health officer within that health officer's jurisdiction.

(b) Notify the department of conditions designated as notifiable to the local health ((~~department~~)) jurisdiction when:

(i) A local health ((~~department~~)) jurisdiction is closed or representatives of the local health ((~~department~~)) jurisdiction are unavailable at the time a ((~~positive preliminary test result or positive~~)) presumptive or final test result of an immediately notifiable condition occurs; or

(ii) ((~~A local health department is closed or representatives of the local health department are unavailable at the time an outbreak or suspected outbreak of communicable disease occurs.~~

~~(c) Notify the department of positive preliminary test results or positive final test results for conditions designated notifiable to the department in Table Lab-1.~~

~~(d) Notify the department of nonelevated blood lead levels on a monthly basis.~~

~~(e) Submit specimens for conditions noted in Table Lab-1 to the Washington state public health laboratories or other laboratory designated by the state health officer for diagnosis, confirmation, storage, or further testing.~~

~~(f) Ensure that positive preliminary test results and positive final test results for notifiable conditions of specimens referred to other laboratories for testing are correctly notified to the correct local health department or the department. This requirement can be satisfied by:~~

~~(i) Arranging for the referral laboratory to notify either the local health department, the department, or both; or~~

~~(ii) Forwarding the notification of the test result from the referral laboratory to the local health department, the department, or both.~~

~~(g)~~)) The notifiable test result pertains to a patient who resides outside of and is visiting Washington state as indicated by information provided by the requesting health care provider or health care facility.

(c) Submit specimens required in Table Lab-1 of WAC 246-101-201 under the requirements of WAC 246-101-210 and 246-101-215, and this section;

(d) Cooperate with public health authorities during investigation of:

(i) The circumstances of a case ((~~or suspected case~~)) of a notifiable condition ((~~or other communicable disease~~)); ((~~and~~)) or

(ii) An outbreak or suspected outbreak of disease.

(2) A laboratory director((~~s~~)) may designate responsibility for working and cooperating with public health authorities to certain employees as long as designated employees are:

(a) Readily available; and

(b) Able to provide requested information in a timely manner.

(3) ((~~By July 1, 2011, when referring~~)) A laboratory director may refer a specimen of a notifiable condition to a reference laboratory for testing.

(4) When a laboratory director refers a specimen ((~~to another~~)) of a notifiable condition to a reference laboratory for ((~~a test for a notifiable condition~~)) testing, the laboratory director((~~s~~)) shall:

(a) Provide the reference laboratory with Table Lab-1 of WAC 246-101-201, and WAC 246-101-220 and 246-101-225; and the following information for each ((~~test referral~~)) specimen:

(((~~(a) Patient name;~~

~~(b) Full address of patient, or patient zip code at a minimum, when available in laboratory database;~~

~~(c) Date of birth or age of patient, when available in laboratory database;~~

~~(d) Sex of patient, when available in laboratory database;~~

~~(e) Name of the principal health care provider;~~

~~(f) Telephone number of the principal health care provider;~~

~~(g) Address of the principal health care provider, when available;~~

~~(h) Type of test requested;~~

~~(i) Type of specimen; and~~

~~(j) Date of specimen collection.~~

~~(4) By January 1, 2013, laboratory databases must have the ability to receive, store, and retrieve all of the data elements specified in subsection (3)(a) through (j) of this section.~~))

(i) Patient's first and last name;

(ii) Patient's physical address including zip code;

(iii) Patient's date of birth;

(iv) Patient's sex;

(v) Patient's race;

(vi) Patient's ethnicity;

(vii) For hepatitis B virus case reports, pregnancy status (pregnant, not pregnant, or unknown) of patients twelve to fifty years of age;

(viii) Patient's best contact telephone number;

(ix) Patient's medicaid status, for blood lead level tests for patients less than seventy-two months of age only;

(x) Requesting health care provider's name;

(xi) Requesting health care provider's phone number;

(xii) Address where patient received care;

(xiii) Name of submitting laboratory;

(xiv) Telephone number of submitting laboratory;

(xv) Specimen type;

(xvi) Specimen collection date;

(xvii) Date laboratory received specimen; and

(xviii) Test method requested.

(b) Ensure the case report is submitted appropriately either by:

(i) Arranging for the reference laboratory to submit the case report under Table Lab-1 of WAC 246-101-201, and WAC 246-101-220 and 246-101-225; or

(ii) Submitting the case report under Table Lab-1 of WAC 246-101-201, and WAC 246-101-220 and 246-101-225.

(5) A laboratory director may provide health information, demographic information, or infectious or noninfectious condition information in addition to the information required under this chapter when the provider or facility determines that the additional information will aid the appropriate public

health authority in protecting and improving the public's health through prevention and control of infectious and non-infectious conditions.

(6) When a laboratory director submits information under subsection (4) of this section, they shall submit the information under the requirements of WAC 246-101-220.

AMENDATORY SECTION (Amending WSR 11-02-065, filed 1/4/11, effective 2/4/11)

WAC 246-101-210 Means of specimen submission—Laboratory directors and laboratories. (1) ((~~When submitting specimens as indicated in Table Lab-1 of WAC 246-101-201, laboratories shall adhere to the following timelines and procedures:~~

~~(a) Specimens designated for submission within two business days must be in transit within two business days from the time the specimen is ready for packaging;~~

~~(b) Specimens designated for submission on request may be requested by the local health departments or the department. The laboratory shall ship a requested specimen within two business days of receiving the request, provided the specimen is still available at the time of the request. This is not intended to require laboratories to save specimens indefinitely in anticipation of a request.~~

~~(2) Local health jurisdictions may temporarily waive specimen submission for circumstances at their discretion by communication with individual laboratories.~~)) A laboratory director shall submit specimens under Table Lab-1 of WAC 246-101-201 and this chapter.

(2) For test results notifiable to local health jurisdictions, the local health officer may temporarily waive specimen submission requirements and notify laboratories, including the Washington state public health laboratories, of the basis for the waiver, which requirements are being waived and how long the waiver will be in effect.

(3) ((~~Laboratories~~)) A laboratory shall forward ((~~all~~)) required specimens ((~~submissions~~)) to:

Washington State Public Health Laboratories
Washington State Department of Health
1610 N.E. 150th Street
Shoreline, WA 98155

(4) The state health officer may designate additional laboratories as public health ((~~referral~~)) reference laboratories.

AMENDATORY SECTION (Amending WSR 11-02-065, filed 1/4/11, effective 2/4/11)

WAC 246-101-215 Content of documentation accompanying specimen submission—Laboratory directors. ((~~For each condition listed in Table Lab-1 of WAC 246-101-201,~~)) A laboratory director((~~s~~)) shall provide the following information with each specimen ((~~submission:~~

~~(1) Type of specimen tested;~~

~~(2) Name of reporting laboratory;~~

~~(3) Telephone number of reporting laboratory;~~

~~(4) Date of specimen collection;~~

~~(5) Requesting health care provider's name;~~

~~(6) Requesting health care provider's phone number;~~

~~(7) Requesting health care provider's address, when available;~~

~~(8) Test result;~~

~~(9) Name of patient;~~

~~(10) Sex of patient, when available in laboratory database;~~

~~(11) Date of birth or age of patient, when available in laboratory database;~~

~~(12) Full address of patient, or patient zip code at a minimum, when available in laboratory database;~~

~~(13) Telephone number of patient, when available in laboratory database;~~

~~(14) Other information of epidemiological value, when available~~)) submitted under this chapter to the Washington state public health laboratories:

(1) Patient's first and last name;

(2) Patient's physical address including zip code;

(3) Patient's date of birth;

(4) Patient's sex;

(5) Patient's race;

(6) Patient's ethnicity;

(7) For hepatitis B virus, pregnancy status (pregnant, not pregnant, or unknown) of patients twelve to fifty years of age;

(8) Patient's best contact telephone number;

(9) Requesting health care provider's name;

(10) Requesting health care provider's phone number;

(11) Address where patient received care;

(12) Name of submitting laboratory;

(13) Telephone number of submitting laboratory;

(14) Specimen type;

(15) Specimen collection date;

(16) Date laboratory received specimen;

(17) Test method used; and

(18) Test result.

AMENDATORY SECTION (Amending WSR 11-02-065, filed 1/4/11, effective 2/4/11)

WAC 246-101-220 Means of notification ((~~for positive preliminary test results and positive final test results~~))—Laboratory directors. A laboratory director((~~s~~)) shall ((~~adhere to the following timelines and procedures:~~

~~(1) Conditions designated as immediately notifiable must be reported to the local health officer or the department, as specified in Table Lab-1 of WAC 246-101-201, immediately at the time of positive preliminary test result or positive final test result. This applies twenty-four hours a day, seven days a week. Each local health jurisdiction, as well as the department, maintains after hours emergency telephone contacts for this purpose. A party sending notification by secure facsimile copy or secure electronic transmission during normal business hours must confirm immediate receipt by a live person.~~

~~(2) Conditions designated as notifiable within twenty-four hours must be reported to the local health officer or the department, as specified in Table Lab-1 of WAC 246-101-201, within twenty-four hours of positive preliminary test result or positive final test result, seven days a week. Reports during normal public health business hours may be sent by~~

~~secure electronic transmission, telephone, or secure facsimile copy of a case report. A party sending a report outside of normal public health business hours must use the after-hours emergency phone contact for the appropriate jurisdiction.~~

~~(3) Conditions designated as notifiable within two business days must be reported to the local health officer or the department, as specified in Table Lab-1 of WAC 246-101-201, within two business days. Notification may be sent by secure electronic transmission, telephone, or secure facsimile copy of a case report; and~~

~~(4) Conditions designated as notifiable on a monthly basis must be reported to the local health officer or the department, as specified in Table Lab-1 of WAC 246-101-201, on a monthly basis. Notification may be sent by written case report, secure electronic transmission, telephone, or secure facsimile copy of a case report~~)):

(1) Submit case reports as required under this chapter by secure electronic data transmission.

(2) Call the local health jurisdiction in which the case occurred immediately and confirm receipt of a presumptive or final test result for a condition designated as:

(a) Immediately notifiable; or

(b) Notifiable within twenty-four hours when submitting the test result outside the local health jurisdiction's normal business hours.

AMENDATORY SECTION (Amending WSR 11-02-065, filed 1/4/11, effective 2/4/11)

WAC 246-101-225 Content of ((~~notifications for positive preliminary test results and positive final test results~~)) case reports—Laboratory directors. (1) ((~~For each condition listed in Table Lab-1 of WAC 246-101-201,~~)) A laboratory director((~~s must~~)) shall provide the following information ((~~for~~)) in each ((~~positive culture or suggestive test result~~)) case report required under this chapter:

(((~~(a) Type of specimen tested;~~

~~(b) Name of reporting laboratory;~~

~~(c) Telephone number of reporting laboratory;~~

~~(d) Date of specimen collection;~~

~~(e) Date specimen received by reporting laboratory;~~

~~(f) Requesting health care provider's name;~~

~~(g) Requesting health care provider's phone number;~~

~~(h) Requesting health care provider's address, when available;~~

~~(i) Test result;~~

~~(j) Name of patient;~~

~~(k) Sex of patient, when available in laboratory database;~~

~~(l) Date of birth or age of patient, when available in laboratory database; and~~

~~(m) Full address of patient, or patient zip code at a minimum, when available in laboratory database.~~)) (a) Patient's first and last name;

(b) Patient's physical address including zip code;

(c) Patient's date of birth;

(d) Patient's sex;

(e) Patient's race;

(f) Patient's ethnicity;

(g) For hepatitis B virus, pregnancy status (pregnant, not pregnant, or unknown) of patients twelve to fifty years of age;

(h) Patient's best contact telephone number;

(i) Patient's medicaid status, for blood lead tests for patients less than seventy-two months of age only;

(j) Requesting health care provider's name;

(k) Requesting health care provider's phone number;

(l) Address where patient received care;

(m) Name of submitting laboratory;

(n) Telephone number of submitting laboratory;

(o) Specimen type;

(p) Specimen collection date;

(q) Date laboratory received specimen;

(r) Test method used; and

(s) Test result.

(2) The local health ((~~officers and~~)) officer or the state health officer may ((~~require laboratory directors to report other~~)) request additional information of epidemiological or public health value when conducting a case investigation or otherwise for prevention and control of a specific notifiable condition.

AMENDATORY SECTION (Amending WSR 11-02-065, filed 1/4/11, effective 2/4/11)

WAC 246-101-230 Handling ((~~of case reports and medical~~)) confidential information—Laboratory directors. (1) All records and specimens ((~~containing~~)) related to a case that contain or are accompanied by patient identifying information are confidential. ((~~The Washington state public health laboratories, other laboratories approved as public health referral laboratories, and any persons, institutions, or facilities submitting specimens or records containing patient-identifying information~~)) Patient identifying information includes information that can directly or indirectly identify a patient.

(2) A laboratory shall maintain the confidentiality of ((~~identifying information accompanying submitted laboratory specimens~~)) health information consistent with chapter 70.02 RCW and any other applicable confidentiality laws.

(((~~(2)~~))) (3) A laboratory director((~~s~~)) shall establish and implement policies and procedures to maintain confidentiality related to ((~~a patient's medical~~)) health information.

(((~~(3) Laboratory directors and personnel working in laboratories who know of a person with a notifiable condition, other than a sexually transmitted disease, shall release identifying information only to other individuals responsible for protecting the health and well-being of the public through control of disease.~~

~~(4) Laboratory directors and personnel working in laboratories with knowledge of a person with sexually transmitted disease, and following the basic principles of health care providers, which respect the human dignity and confidentiality of patients:~~

~~(a) May disclose identity of a person or release identifying information only as specified in RCW 70.24.105; and~~

~~(b) Shall under RCW 70.24.105(6), use only the following customary methods for exchange of medical information:~~

~~(i) Laboratory directors and personnel working in laboratories may exchange medical information related to HIV testing, HIV test results, and confirmed HIV or confirmed STD diagnosis and treatment in order to provide health care services to the patient. This means that information shared impacts the care or treatment decisions concerning the patient; and the laboratory director or personnel working in the laboratory require the information for the patient's benefit.~~

~~(ii) Laboratory directors are authorized to permit access to a patient's medical information and medical record by laboratory staff or office staff to carry out duties required for care and treatment of a patient, the management of medical information, and the management of the patient's medical record.~~))

PART IV: NOTIFIABLE CONDITIONS—DUTIES OF OTHERS

AMENDATORY SECTION (Amending WSR 11-02-065, filed 1/4/11, effective 2/4/11)

WAC 246-101-405 ((~~Responsibilities of~~)) Duties—Veterinarians. (1) A veterinarian((~~s~~)) shall((~~:~~

~~(a) Notify the local health officer of the jurisdiction in which the human resides of any suspected human case or suspected human outbreak based on the human's exposure to a confirmed animal case of any disease listed in Table V-1 of this section:~~

~~Table V-1 (Conditions Notifiable by Veterinarians)~~

~~Notifiable Condition~~	~~Time Frame for Notification~~	~~Notifiable to Local Health Department~~
~~Anthrax~~	~~Immediately~~	~~√~~
~~Arboviral Disease~~	~~Within 24 hours~~	~~√~~
~~Brucellosis (*Brucella* species)~~	~~Within 24 hours~~	~~√~~
~~*Burkholderia mallei* (Glanders)~~	~~Immediately~~	~~√~~
~~Disease of suspected bioterrorism origin (including but not limited to anthrax)~~	~~Immediately~~	~~√~~
~~E. coli - Refer to "Shiga toxin-producing *E. coli*"~~	~~Immediately~~	~~√~~
~~Emerging condition with outbreak potential~~	~~Immediately~~	~~√~~
~~Influenza virus, novel or unsubtypable strain~~	~~Immediately~~	~~√~~
~~Leptospirosis~~	~~Within 24 hours~~	~~√~~
~~Plague~~	~~Immediately~~	~~√~~
~~Psittacosis~~	~~Within 24 hours~~	~~√~~
~~Q Fever~~	~~Within 24 hours~~	~~√~~
~~Rabies (suspected human or animal)~~	~~Immediately~~	~~√~~
~~Shiga toxin-producing *E. coli* infections (enterohemorrhagic *E. coli* including, but not limited to, *E. coli* O157:H7)~~	~~Immediately~~	~~√~~
~~Tularemia~~	~~Immediately~~	~~√~~

~~(√) Indicates that the condition is notifiable to the local health department.~~

~~(b)~~))) cooperate with public health authorities in ((~~the~~)) their:

(a) Investigation of human and animal cases, ((~~suspected cases,~~)) outbreaks, ((~~and~~)) suspected outbreaks, and clusters of zoonotic disease((~~.~~

~~(c) Cooperate with public health authorities in the implementation of infection control measures including isolation and quarantine.~~

~~(d) Comply with requirements in chapter 16-70 WAC for submitting positive specimens and isolates for specific diseases, and provide information requested by the department or local health jurisdiction.~~

~~(2) The department of health shall:~~

~~(a) Coordinate with the state veterinarian at the department of agriculture to develop, maintain, and implement a procedure for notifying the department of animal cases of the conditions listed in Table V-1 of this section.~~

~~(b) Notify the local health jurisdiction of reported animal cases of the conditions in Table V-1 of this section~~)); and

(b) Implementation of infection control measures.

(2) Cooperation with public health authorities includes, but is not limited to:

(a) Providing information requested by the department or local health jurisdiction; and

(b) Following infection control measures for:

(i) Humans under chapter 246-100 WAC;

(ii) Dogs, cats, ferrets, and hybrids under WAC 246-100-197; and

(iii) Other animals under chapter 16.36 RCW.

AMENDATORY SECTION (Amending WSR 11-02-065, filed 1/4/11, effective 2/4/11)

WAC 246-101-410 ((Responsibilities of food service)) Duties—Food establishments. The person in charge of a food ((service)) establishment shall:

(1) For the purposes of this section "food establishment" has the same meaning as defined and referenced under WAC 246-215-01115.

(2) Notify the local health ((department)) jurisdiction of potential foodborne disease as required in WAC ((246-215-260)) 246-215-02215.

(((2))) (3) Cooperate with public health authorities in ((the)) their investigation and control of cases, ((suspected cases,)) outbreaks, and suspected outbreaks ((of foodborne or waterborne disease)). This includes, but is not limited to, the release of the name and other pertinent information about food handlers diagnosed with a notifiable condition or other communicable disease ((as it relates to a foodborne or waterborne disease investigation)).

(((3))) (4) Not release information about food handlers with a notifiable condition or other communicable disease to other employees or the general public.

AMENDATORY SECTION (Amending WSR 11-02-065, filed 1/4/11, effective 2/4/11)

WAC 246-101-415 ((Responsibilities of child day)) Duties—Child care facilities. (1) For the purposes of this section "child care facility" means an agency that regularly provides early childhood education and early learning services for a group of children for less than twenty-four hours a day and is subject to licensing under chapter 74.15 or 43.216 RCW, or both.

(2) A child ((day)) care ((facilities)) facility shall:

(((1))) (a) Notify the local health ((department)) jurisdiction of cases, ((suspected cases,)) outbreaks, and suspected outbreaks of notifiable conditions in Table HC-1 of WAC 246-101-101 that may be associated with the child ((day)) care facility.

(((2))) (b) Consult with a health care provider or the local health ((department)) jurisdiction for information about the control and prevention of infectious ((or communicable disease)) conditions, as necessary.

(((3))) (c) Cooperate with public health authorities in ((the)) their investigation and control of cases, ((suspected cases,)) outbreaks, and suspected outbreaks ((of disease)) that may be associated with the child ((day)) care facility.

(((4))) (d) Establish and implement policies and procedures to maintain confidentiality related to ((medical)) health information in their possession.

AMENDATORY SECTION (Amending WSR 11-02-065, filed 1/4/11, effective 2/4/11)

WAC 246-101-420 ((Responsibilities of)) Duties—Schools. A school((s)) shall:

(1) Notify the local health ((department)) jurisdiction of cases, ((suspected cases,)) outbreaks, and suspected outbreaks of ((disease)) notifiable conditions in Table HC-1 of WAC 246-101-101 that may be associated with the school.

(2) Cooperate with the local health ((department)) jurisdiction in monitoring influenza.

(3) Consult with a health care provider or the local health ((department)) jurisdiction for information about the control and prevention of infectious ((or communicable disease)) conditions, as necessary.

(4) Cooperate with public health authorities in ((the)) their investigation and control of cases, ((suspected cases,)) outbreaks, and suspected outbreaks ((of disease)) that may be associated with the school.

(5) Release identifying information only to other individuals responsible for protecting the health and well-being of the public through control of disease consistent with applicable confidentially laws.

(6) ((Schools shall)) Establish and implement policies and procedures to maintain confidentiality related to ((medical)) health information in their possession.

AMENDATORY SECTION (Amending WSR 11-02-065, filed 1/4/11, effective 2/4/11)

WAC 246-101-425 ((Responsibilities of)) Duties—The general public. (1) Members of the general public shall cooperate with:

(a) ((Cooperate with)) Public health authorities in ((the)) their investigation and control of cases, ((suspected cases,)) outbreaks, and suspected outbreaks ((of notifiable conditions or other communicable diseases)); and

(b) ((Cooperate with the)) Implementation of infection control measures((, including isolation and quarantine)).

(2) Members of the general public may notify the local health ((department)) jurisdiction of any case, ((suspected case,)) outbreak, or ((potential)) suspected outbreak ((of communicable disease)).

PART V: NOTIFIABLE CONDITIONS ((AND))—LOCAL HEALTH JURISDICTIONS ((AND THE DEPARTMENT))

AMENDATORY SECTION (Amending WSR 11-02-065, filed 1/4/11, effective 2/4/11)

WAC 246-101-505 Duties ((of the))—Local health officer or the local health ((department)) jurisdiction. (1) A local health officer((s)) or ((the)) local health ((department)) jurisdiction shall:

(a) Review and determine appropriate action for:

(i) Each ((reported)) case ((or suspected case)) of a notifiable condition submitted to the local health jurisdiction;

(ii) Any ((disease or)) condition considered a threat to public health; and

(iii) Each ((reported)) outbreak or suspected outbreak of disease ((, requesting)) submitted to the local health jurisdiction, and request assistance from the department in carrying out any of these investigations when necessary.

(b) Establish a system at the local health ((department)) jurisdiction for maintaining confidentiality of ((written)) records ((and written and telephoned notifiable conditions case reports)) under WAC 246-101-515;

(c) Notify health care providers, laboratories, and health care facilities within the ((~~jurisdiction of the~~)) local health ((~~department~~)) jurisdiction of requirements in this chapter;

(d) Notify the department of cases of ((~~any~~)) conditions notifiable to the local health ((~~department (except animal bites) upon completion of the case investigation~~)) jurisdiction under WAC 246-101-510 and 246-101-513;

(e) ((~~Distribute appropriate notification forms to persons responsible for reporting;~~

~~(f)~~)) Notify the principal health care provider named in the case report, if possible, prior to initiating a case investigation ((~~by the local health department~~));

(((~~(g) Carry out the HIV partner notification requirements of WAC 246-100-072;~~

~~(h)~~))) (f) Allow laboratories to contact the health care provider ordering the diagnostic test before initiating patient contact if requested and the delay is unlikely to jeopardize public health; and

(((~~(i)~~))) (g) Conduct investigations and institute infection control measures in accordance with chapter 246-100 WAC.

(2) The local health ((~~department~~)) jurisdiction may:

(a) Adopt alternate arrangements for meeting the ((~~reporting~~)) requirements under this chapter through cooperative agreement between the local health ((~~department~~)) jurisdiction and any health care provider, laboratory, or health care facility((~~,~~)). The alternative must provide the same level of public health protection as the reporting requirement for which an alternative is sought;

(b) Receive health information, demographic information, and infectious or noninfectious condition information in addition to that required under this chapter from health care providers, health care facilities, laboratories, the department of agriculture, and the department of labor and industries when the entity submitting the information determines that the additional information will aid the public health authority in protecting and improving the public's health through prevention and control of infectious and noninfectious conditions.

(3) When the local health jurisdiction receives information under subsection (2)(b) of this section, the local health jurisdiction shall handle the information under the requirements of WAC 246-101-515.

(4) Each local health officer has the authority under chapter 70.05 RCW to:

(a) Carry out additional steps ((~~determined to be~~)) necessary to verify a diagnosis reported by a health care provider;

(b) Require any person suspected of having a notifiable condition to submit to examinations ((~~required~~)) necessary to determine the presence or absence of the condition;

(c) Investigate any case ((~~or suspected case~~)) of a ((~~reportable disease or~~)) notifiable condition or other ((~~illness, communicable or otherwise~~)) infectious or noninfectious condition, if deemed necessary; and

(d) Require the notification of additional conditions of public health importance occurring within the jurisdiction of the local health officer.

AMENDATORY SECTION (Amending WSR 11-02-065, filed 1/4/11, effective 2/4/11)

WAC 246-101-510 Means of notification—Local health officer or local health jurisdiction. (1) A local health ((~~departments~~)) jurisdiction shall:

(a) Maintain a twenty-four-hour telephone number to receive confirmation calls of case reports submitted under this chapter for:

(i) Immediately notifiable conditions; and

(ii) Conditions designated as notifiable within twenty-four hours.

(b) Notify the department immediately ((~~by telephone or secure electronic data transmission of any case or suspected case of:~~

~~(a) Botulism;~~

~~(b) Cholera;~~

~~(c) Diphtheria;~~

~~(d) Disease of suspected bioterrorism origin (including, but not limited to, anthrax);~~

~~(e) Emerging condition with outbreak potential;~~

~~(f) Influenza, novel strain;~~

~~(g) Measles;~~

~~(h) Paralytic shellfish poisoning;~~

~~(i) Plague;~~

~~(j) Poliomyelitis;~~

~~(k) Rabies, human;~~

~~(l) SARS;~~

~~(m) Smallpox;~~

~~(n) Tularemia;~~

~~(o) Viral hemorrhagic fever; and~~

~~(p) Yellow fever.~~

~~(2) Immediate notifications of cases and suspected cases shall include:~~

~~(a) Patient name;~~

~~(b) Patient's notifiable condition; and~~

~~(c) Condition onset date.~~

~~(3) For each case of any condition notifiable to the local health department, submit to the department case report either on a form provided by the department or in a format approved by the department. Case reports must be sent by secure electronic transmission or telephone within seven days of completing the case investigation. If the case investigation is not complete within twenty-one days of notification, pertinent information collected from the case investigation must be sent to the department and shall include:~~

~~(a) Patient name;~~

~~(b) Patient's notifiable condition or suspected condition;~~

~~(c) Source or suspected source; and~~

~~(d) Condition onset date.~~

~~(4) Local health officials will report asymptomatic HIV infection cases to the department according to a standard code developed by the department.~~

~~(5) When notified of an outbreak or suspected outbreak of illness due to an infectious agent or toxin, the local health department shall:~~

~~(a) Notify the department immediately by telephone or secure electronic data transmission.~~

~~(b) Include in the initial notification:~~

~~(i) Organism or suspected organism;~~

~~(ii) Source or suspected source; and~~

~~(iii) Number of persons affected.~~

~~(c) Within seven days of completing the outbreak investigation, submit~~)) using either telephone or secure electronic data transmission:

(i) Upon receiving a case report for a condition that is immediately notifiable to the local health jurisdiction under this chapter, excluding Meningococcal disease, invasive (Neisseria meningitides); Shiga toxin-producing *E. coli* (STEC)/enterohemorrhagic *E. coli*; and Vaccinia (vaccine-acquired smallpox); and

(ii) Of an outbreak or suspected outbreak within their jurisdiction;

(c) Notify the department using a secure electronic disease surveillance system within three business days of receiving a case report for a condition that is not immediately notifiable to the local health jurisdiction under this chapter;

(d) If after submitting a notification to the department, the local health officer determines no further investigation is necessary, indicate in the secure electronic disease surveillance system that no further investigation is warranted within three business days of the determination.

(e) Immediately reassign cases to the department upon determining the patient who is the subject of the case:

(i) Is a resident of another local health jurisdiction; or

(ii) Resides outside Washington state.

(f) Submit a case report to the department using a secure electronic disease surveillance system for each case report received by the local health jurisdiction for which the local health officer determined an investigation was necessary:

(i) Within seven days of completing the investigation for any condition notifiable to the local health jurisdiction; or

(ii) Within twenty-one days of receiving the case report if the investigation is not complete.

(g) Submit an outbreak report to the department ((~~a report on forms provided by the department or in a format approved by the department~~)) using secure electronic data transmission within seven days of completing an outbreak investigation. The department may waive this requirement if ((~~telephone or secure electronic data transmission~~)) notification under (b)(ii) of this subsection provided ((~~pertinent~~)) sufficient information.

(2) The local health officer shall confirm that each case is based on clinical criteria, or laboratory criteria, or both prior to submitting the case report to the department. This criteria includes, but is not limited to, the Centers for Disease Control and Prevention, National Notifiable Diseases Surveillance System, Council of State and Territorial Epidemiologists case definitions.

NEW SECTION

WAC 246-101-513 Content of notifications, case reports, and outbreak reports—Local health officer. A local health officer shall provide the following information for each notification, case report, and outbreak report submitted under WAC 246-101-510:

(1) Notifications must include:

(a) Patient's first and last name;

(b) Patient's notifiable condition;

(c) Date local health jurisdiction was notified;

(d) Condition symptom onset date (preferred), or alternatively, diagnosis date;

(e) Patient's date of birth; and

(f) Patient's sex.

(2) Case reports must include:

(a) Patient's first and last name;

(b) Patient's date of birth;

(c) Patient's race;

(d) Patient's ethnicity;

(e) For hepatitis B acute or chronic infection case reports, pregnancy status (pregnant, not pregnant, or unknown) of patients twelve to fifty years of age;

(f) Investigation start date;

(g) Investigation completion date;

(h) Initial notification source;

(i) Hospitalization status of patient;

(j) Whether the patient died during this illness;

(k) Probable geographic region of exposure (i.e., county, state, or country other than the United States of America);

(l) Travel out of the country (as applicable);

(m) Whether the case is associated with an ongoing outbreak investigation; and

(n) The data used to verify the case meets clinical criteria, or laboratory criteria, or both. This includes, but is not limited to, the Centers for Disease Control and Prevention, National Notifiable Diseases Surveillance System, Council of State and Territorial Epidemiologists case definitions.

(3) Outbreak reports must include:

(a) Organism or suspected organism;

(b) Source or suspected source; and

(c) Number of persons infected and potentially exposed.

AMENDATORY SECTION (Amending WSR 11-02-065, filed 1/4/11, effective 2/4/11)

WAC 246-101-515 Handling ((~~of case reports and medical~~)) confidential information—Local health officers and local health jurisdictions. (1) All records and specimens related to a case, that contain or are accompanied by patient identifying information are confidential. Patient identifying information includes information that can directly or indirectly identify a patient.

(2) Local health officers and local health jurisdiction employees shall maintain the confidentiality of health information consistent with chapter 70.02 RCW and RCW 42.56.360(2).

(3) Local health officers or local health ((~~departments~~)) jurisdictions shall establish and ((~~maintain~~)) implement confidentiality policies and procedures related to employee handling of ((~~all reports of cases and suspected cases, prohibiting disclosure of report information identifying an individual case or suspected cases except:~~

~~(a) To employees of the local health department, another local health department, or other official agencies needing to know for the purpose of administering public health laws and these regulations;~~

~~(b) To health care providers, designees of health care facilities, laboratory directors, and others for the purpose of collecting additional information about a case or suspected case as required for disease prevention and control;~~

~~(2)~~)) health information under this chapter and chapters 70.02 and 70.24 RCW and RCW 42.56.360(2).

(4) Local health officers shall ((~~require and maintain signed confidentiality agreements with~~)):

(a) Require all local health ((~~department~~)) jurisdiction employees with access to ((~~identifying~~)) health information ((~~related to a case or suspected case of a person diagnosed with a notifiable condition. The agreements will be renewed~~)) to sign confidentiality agreements;

(b) Retain current signed confidentiality agreements;

(c) Reference in confidentiality agreements the penalties for violation of chapter 70.24 RCW and administrative actions that may be taken by the local health jurisdiction if the confidentiality agreement is violated; and

(d) Renew confidentiality agreements at least annually ((~~and will include reference to criminal and civil penalties for violation of chapters 70.02 and 70.24 RCW and other administrative actions that may be taken by the local health department.~~

~~(3) Local health departments may release statistical summaries and epidemiological studies based on individual case reports if no individual is identified or identifiable~~)).

AMENDATORY SECTION (Amending WSR 06-16-117, filed 8/1/06, effective 9/1/06)

WAC 246-101-520 Special conditions—AIDS and HIV—Local health officers and local health jurisdictions. (1) The local health officer and local health ((~~department~~)) jurisdiction personnel shall maintain individual case reports for AIDS and HIV as confidential records consistent with the requirements of this section.

(2) The local health officer and local health ((~~department~~)) jurisdiction personnel ((~~must~~)) shall:

(a) Use identifying information ((~~on~~)) of HIV-infected individuals only:

(i) ((~~For purposes of contacting~~)) To contact the HIV-positive individual to provide test results and post-test counseling or referring the individual to social and health services; or

(ii) To contact persons who have experienced substantial exposure, including sex and injection equipment-sharing partners, and spouses; or

(iii) To link with other name-based public health disease registries when doing so will improve ability to provide needed care services and counseling and disease prevention, provided that the identity or identifying information of the HIV-infected person is not disclosed outside of the local health jurisdiction; or

(iv) As specified in WAC 246-100-072; or

(v) To provide case reports to the ((~~state health~~)) department; or

(vi) To conduct investigations under RCW 70.24.022 or 70.24.024.

(b) Destroy case report identifying information on asymptomatic HIV-infected individuals received as a result of this chapter within ((~~three months~~)) ninety days of receiving a complete case report, or maintain HIV case reports in secure systems ((~~that meet the following standards and are~~)) consistent with the ((~~2006~~)) 2011 *Data Security and Confidentiality Guidelines* ((~~developed~~)) *for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs: Standards to Facilitate Sharing and Use of Surveillance Data for Public Health Action* published by the Centers for Disease Control and Prevention.

(3) The local health officer shall:

(((~~i~~))) (a) Describe the secure systems ((~~must be described~~)) in written policies ((~~that are reviewed~~)) and review the policies annually ((~~by the local health officer~~));

(((~~ii~~))) (b) Limit access to case report information ((~~must be limited~~)) to local health ((~~department~~)) jurisdiction staff who need ((~~it~~)) the information to perform their job duties ((~~and~~));

(c) Maintain a current list of ((~~these~~)) local health jurisdiction staff ((~~must be maintained by the local health officer~~)) with access to case report information;

(((~~iii) All~~))) (d) Enclose physical locations containing electronic or paper copies of surveillance data ((~~must be enclosed~~)) in a locked, secured area with limited access and not accessible by window;

(((~~iv~~))) (e) Store paper copies or electronic media containing surveillance information ((~~must be housed~~)) inside locked file cabinets that are in the locked, secured area;

(((~~v~~))) (f) Destroy information by either shredding it with a crosscut shredder ((~~must be available for destroying information and~~)) or appropriately sanitizing electronic media ((~~must be appropriately sanitized~~)) prior to disposal;

(((~~vi~~))) (g) Store files or databases containing confidential information ((~~must reside~~)) on either stand-alone computers with restricted access or on networked drives with proper access controls, encryption software, and firewall protection;

(((~~vii~~))) (h) Protect electronic communication of confidential information ((~~must be protected~~)) by encryption standards ((~~that are reviewed annually by the local health officer~~)) and review the standards annually; and

(((~~viii~~))) (i) Make available locking briefcases ((~~must be available~~)) for transporting confidential information((~~;~~

~~(c)~~)).

(4) The local health officer and local health jurisdiction staff shall:

(a) If maintaining identifying information on asymptomatic HIV-infected individuals more than ninety days following receipt of a completed case report, cooperate with the department ((~~of health~~)) in biennial review of system security measures described in subsection (2)(b) of this ((~~subsection~~)) section.

(((~~d~~))) (b) Destroy documentation of referral information established in WAC 246-100-072 containing identities and identifying information on HIV-infected individuals and at-risk partners of those individuals immediately after notifying partners or within ((~~three months~~)) ninety days, whichever occurs first, unless such documentation is being used in an investigation of conduct endangering the public health or of behaviors presenting an imminent danger to the public health ((~~pursuant to~~)) under RCW 70.24.022 or 70.24.024.

(((~~e~~))) (c) Not disclose identifying information received as a result of this chapter unless:

(i) Explicitly and specifically required to do so by state or federal law; or

(ii) Authorized by written patient consent.

(((~~(2) Local health department personnel are authorized to use HIV identifying information obtained as a result of this chapter only for the following purposes:~~

~~(a) Notification of persons with substantial exposure, including sexual or syringe sharing partners;~~

~~(b) Referral of the infected individual to social and health services;~~

~~(c) Linkage to other public health databases, provided that the identity or identifying information on the HIV-infected person is not disclosed outside of the health department; and~~

~~(d) Investigations pursuant to RCW 70.24.022 or 70.24.024.~~

~~(3) Public health databases do not include health professions licensing records, certifications or registries, teacher certification lists, other employment rolls or registries, or databases maintained by law enforcement officials.~~

~~(4) Local health officials will report HIV infection cases to the state health department.~~

~~(5) Local health officers must require and maintain signed confidentiality agreements with all health department employees with access to HIV identifying information. These agreements will be renewed at least annually and include reference to criminal and civil penalties for violation of chapter 70.24 RCW and other administrative actions that may be taken by the department.~~

~~(6)~~)) (5) Local health officers ((~~must~~)) shall investigate potential breaches of the confidentiality of HIV identifying information by health ((~~department~~)) jurisdiction employees. The local health officer shall report all breaches of confidentiality ((~~must be reported~~)) to the state health officer ((~~or their designee~~)) for review and appropriate action.

(((~~(7) Local health officers and local health department personnel must assist the state health department to reascertain the identities of previously reported cases of HIV infection.~~)))

AMENDATORY SECTION (Amending WSR 00-23-120, filed 11/22/00, effective 12/23/00)

WAC 246-101-525 Special condition—Influenza—Local health jurisdictions. A local health ((~~departments~~)) jurisdiction shall:

(1) Maintain a surveillance system for influenza during the ((~~appropriate~~)) influenza season which may include:

(a) Monitoring of excess school absenteeism;

(b) ((~~Sample check with~~)) Requesting information from health care providers((~~, clinics, nursing homes, and hospitals~~)) and health care facilities regarding influenza-like illnesses; and

(c) Monitoring ((~~of~~)) workplace absenteeism and other mechanisms.

(2) ((~~Encourage~~)) Request submission of appropriate clinical specimens from a sample of patients with influenza-like illness to the Washington state public health laboratories or other laboratory approved by the state health officer.

PART VI: NOTIFIABLE CONDITIONS—DEPARTMENT OF HEALTH

AMENDATORY SECTION (Amending WSR 11-02-065, filed 1/4/11, effective 2/4/11)

WAC 246-101-605 Duties ((~~of the~~))—Department ((~~of health~~)). (1) The department shall:

(a) Upon request, provide consultation and technical assistance to local health ((~~departments and~~)) jurisdictions, the department of labor and industries, and the department of agriculture when they are investigating notifiable conditions ((~~reports upon request~~)).

(b) Upon request, provide consultation and technical assistance to health care providers, laboratories, health care facilities, and others required to ((~~make notifications to public health authorities of notifiable conditions upon request~~)) comply with this chapter.

(c) Develop, maintain, and make available for local health ((~~departments~~)) jurisdictions guidance on investigation and control measures for notifiable ((~~communicable disease~~)) conditions.

(d) ((~~Develop and~~)) Make case report forms available ((~~forms for the submission of notifiable conditions data~~)) to local health ((~~departments~~)) jurisdictions, health care providers, laboratories, health care facilities, and others required to ((~~make notifications to public health authorities of notifiable conditions~~)) comply with this chapter.

(e) Maintain a twenty-four hour telephone number ((~~for reporting notifiable conditions~~)) to receive:

(i) Confirmation calls for immediately notifiable condition case reports; and

(ii) Notification of immediately notifiable case reports or outbreaks and suspected outbreaks from local health jurisdictions.

(f) Develop routine data dissemination mechanisms that describe and analyze notifiable conditions case investigations and data((~~. These may include annual and monthly reports and other mechanisms for data dissemination as developed by the department~~)) in accordance with WAC 246-101-615.

(g) Conduct investigations and institute infection control measures as necessary.

(h) Document the known environmental, human, and other variables associated with a case ((~~or suspected case~~)) of pesticide poisoning.

(i) Report the results of the pesticide poisoning investigation to the principal health care provider named in the case report ((~~form~~)) and to the local health officer in whose jurisdiction the ((~~exposure has~~)) case occurred.

(2) The department may:

(a) Negotiate ((~~alternate arrangements~~)) alternatives for meeting ((~~reporting~~)) requirements under this chapter through cooperative agreement between the department and any health care provider, laboratory, ((~~or~~)) health care facility, or state agency. An alternative must provide the same level of public health protection as the reporting requirement for which an alternative is sought.

(b) ((~~Consolidate reporting for notifiable conditions from any~~)) Under an approved cooperative agreement, relieve a health care provider, laboratory, or health care facil-

ity((~~, and relieve that health care provider, laboratory, or health care facility from reporting directly to each~~)) of the duty to notify a local health ((~~department~~)) jurisdiction, if the department can ((~~provide the report~~)) consolidate and submit notifications to the local health ((~~department~~)) jurisdiction within the ((~~same time as the local health department would have otherwise received it~~)) time frame for notification required under Table HC-1 of WAC 246-101-101 and Table Lab-1 of WAC 246-101-201.

(c) Receive health information, demographic information, and infectious or noninfectious condition information in addition to that required under this chapter from health care providers, health care facilities, laboratories, and public health authorities.

(3) When the department receives information under subsection (2)(c) of this section, the department shall handle the information under the requirements of WAC 246-101-610.

AMENDATORY SECTION (Amending WSR 11-02-065, filed 1/4/11, effective 2/4/11)

WAC 246-101-610 Handling of ((~~case reports and medical~~)) confidential information and information exempt from public disclosure—State health officer and department. (1) All records and specimens related to a case that contain or are accompanied by patient identifying information are confidential. Patient identifying information includes information that can directly or indirectly identify a patient.

(2) The state health officer and department employees shall maintain the confidentiality of health information in accordance with chapter 70.02 RCW and RCW 42.56.360(2).

(3) The state health officer ((~~or designee~~)) shall establish and ((~~maintain~~)) implement confidentiality policies and procedures related to employee handling of ((~~all reports of cases and suspected cases, prohibiting disclosure of report information identifying an individual case or suspected cases except:~~

~~(a) To employees of the local health department, other local health departments, or other official agencies needing to know for the purpose of administering public health laws and these regulations.~~

~~(b) To health care providers, specific designees of health care facilities, laboratory directors, and others for the purpose of collecting additional information about a case or suspected case as required for disease prevention and control.~~

~~(c) For research approved by an institutional review board as indicated under chapter 42.48 RCW. The institutional review board applies federal and state privacy laws to research requests for confidential information.~~

~~(2)~~)) health information under this chapter and in accordance with chapters 70.02 and 70.24 RCW and RCW 42.56.360(2).

(4) The state health officer or department shall:

(a) Require all department employees, contractors, and others with access to ((~~identifying~~)) health information ((~~related to a case or suspected case of a person diagnosed with a notifiable condition shall be required~~)) to sign ((~~a~~)) confidentiality agreements((~~. The~~)):

(b) Retain current signed confidentiality agreements;

(c) Reference in confidentiality agreements the penalties for violation of chapter 70.24 RCW and administrative actions that may be taken by the department if the confidentiality agreement is violated; and

(d) Renew confidentiality agreements ((~~shall be renewed~~)) at least annually ((~~and shall include reference to criminal and civil penalties for violation of chapters 70.02 and 70.24 RCW and other administrative actions that may be taken by the department~~)).

AMENDATORY SECTION (Amending WSR 11-02-065, filed 1/4/11, effective 2/4/11)

WAC 246-101-615 ((~~Requirements for~~)) Data dissemination and notification—Department. The department shall:

(1) Distribute periodic epidemiological summary reports and an annual review of public health issues to local health officers ((~~and~~)), local health ((~~departments~~)) jurisdictions, and the department of labor and industries.

(2) ((~~Upon execution of a data sharing agreement,~~)) Make available ((~~any data or other~~)) case investigation documentation ((~~in its possession regarding~~)) for notifiable conditions reported directly to the department to local health officers or ((~~their designees within two days of a request~~)) the department of labor and industries within twenty-four hours of receipt by the department.

(3) Make other data necessary to conduct case investigations or epidemiological summaries available within two business days of a request from a public health authority.

(((~~3~~))) (4) Periodically distribute statistical summaries and epidemiological studies based on individual case reports if no ((~~individual~~)) patient is identified or identifiable.

AMENDATORY SECTION (Amending WSR 00-23-120, filed 11/22/00, effective 12/23/00)

WAC 246-101-630 Special condition—Antibiotic resistant disease—Department. The department shall((~~:~~

~~(1)~~)) maintain a surveillance system for monitoring antibiotic resistant disease ((~~that may include~~)) including, but not limited to:

(((~~a~~))) (1) Development of a sentinel network of laboratories to provide information regarding antibiotic resistant disease; and

(((~~b~~))) (2) Sample checks with health care providers((~~, clinics, and hospitals~~)) and health care facilities regarding antibiotic resistant disease.

(((~~(2) Encourage submission of appropriate clinical~~))) (3) Request the health care providers and laboratories submit specimens from a sample of patients with antibiotic resistant disease to the Washington state public health laboratories or other laboratory approved by the state health officer.

AMENDATORY SECTION (Amending WSR 06-16-117, filed 8/1/06, effective 9/1/06)

WAC 246-101-635 Special conditions—AIDS and HIV—Department. The following provisions apply ((~~for~~)) to the use of AIDS and HIV notifiable conditions case

reports, related information, and data and is in addition to the requirements established under WAC 246-101-610:

(1) Department personnel ((~~must~~)) shall not disclose identifying information ((~~received as a result of receiving information regarding a notifiable conditions report of~~)) related to a case of AIDS or HIV unless:

(a) Explicitly and specifically required to do so by state or federal law; or

(b) Authorized by written patient consent.

(2) Department personnel ((~~are authorized to~~)) may use HIV identifying information ((~~received as a result of receiving information regarding a notifiable conditions report of~~)) related to a case of AIDS or HIV only for the following purposes:

(a) Notification of persons with substantial exposure, including sexual or syringe-sharing partners;

(b) Referral of the infected individual to social and health services; and

(c) Linkage to other public health databases, provided that the identity or identifying information ((~~on~~)) of the HIV-infected person is not disclosed outside ((~~of~~)) the ((~~health~~)) department.

(3) ((~~For the purposes of this chapter, public health databases do not include health professions licensing records, certifications or registries, teacher certification lists, other employment rolls or registries, or databases maintained by law enforcement officials.~~

~~(4)~~)) The state health officer ((~~must~~)) shall require and maintain signed confidentiality agreements with all department employees with access to HIV identifying information. The state health officer shall ensure these agreements ((~~will be~~)) are renewed at least annually and include reference to ((~~criminal and civil~~)) penalties for violation of chapter 70.24 RCW and ((~~other~~)) administrative actions that may be taken by the department.

(((~~5~~))) (4) The state health officer ((~~must~~)) shall investigate potential breaches of the confidentiality of HIV identifying information by department employees. All breaches of confidentiality shall be reported to the state health officer or their authorized representative for review and appropriate action.

(((~~6~~))) (5) The department ((~~must~~)) shall maintain all HIV case reports in a name-based surveillance system solely for the purpose of complying with HIV reporting guidelines from the ((~~federal~~)) Centers for Disease Control and Prevention, and ((~~must~~)) shall not disclose or otherwise use any information contained in that system for any other purpose, except as expressly permitted by this section.

(((~~7) Authorized representatives of the department must review available records to reascertain the identities of previously reported cases of asymptomatic HIV infection and retain those cases in a confidential name-based system.~~

~~(8)~~)) (6) The department ((~~must~~)) shall:

(a) Maintain HIV case reports in secure systems that meet the following standards and are consistent with the ((~~2006~~)) 2011 *Data Security and Confidentiality Guidelines* ((~~developed~~)) *for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs: Standards to Facilitate Sharing and Use of Surveillance Data for Public Health Action* published by the Centers for Disease Control and Prevention((~~:~~

~~(a)~~));

(b) Describe secure systems ((~~must be described~~)) in written policies ((~~that are reviewed~~)) and review the policies annually ((~~by the overall responsible party~~));

(((~~b~~))) (c) Limit access to case report information ((~~must be limited~~)) to ((~~health~~)) department staff who need it to perform their job duties ((~~and~~));

(d) Maintain a current list of ((~~these~~)) department staff ((~~must be maintained by the overall responsible party~~)) with access to case report information;

(((~~c~~))) (e) Enclose all physical locations containing electronic or paper copies of surveillance data ((~~must be enclosed~~)) in a locked, secured area with limited access and not accessible by window;

(((~~d~~))) (f) Store paper copies or electronic media containing surveillance information ((~~must be housed~~)) inside locked file cabinets that are in the locked, secured area;

(((~~e~~))) (g) Destroy information by either shredding it with a crosscut shredder ((~~must be available for destroying information and~~)) or appropriately sanitizing electronic media ((~~must be appropriately sanitized~~)) prior to disposal;

(((~~f~~))) (h) Store files or databases containing confidential information ((~~must reside~~)) on either stand-alone computers with restricted access or on networked drives with proper access controls, encryption software, and firewall protection;

(((~~g~~))) (i) Protect electronic communication of confidential information ((~~must be protected~~)) by encryption standards ((~~that are reviewed~~)) and review the standards annually ((~~by the overall responsible party~~));

(((~~h~~))) (j) Use locking briefcases ((~~must be available~~)) for transporting confidential information.

(((~~9~~))) (7) The state health officer ((~~or designee must~~)) shall conduct a biennial review of local health jurisdictions system security measures described in WAC 246-101-520 ((~~(1)(b) at local health jurisdictions~~)) that are maintaining records by name.

(((~~10~~))) (8) When providing technical assistance to a local health ((~~department~~)) jurisdiction, authorized representatives of the department may temporarily, and subject to the time limitations in WAC 246-101-520, receive the names of reportable cases of HIV infection for the purpose of partner notification, or special studies. Upon completion of the activities by representatives of the ((~~state health~~)) department, named information will be provided to the local health ((~~department~~)) jurisdiction subject to the provisions of WAC 246-101-520.

(((~~(11) By December 2007, the state health officer, in cooperation with local health officers, will report to the board on:~~

~~(a) The ability of the HIV reporting system to meet surveillance performance standards established by the federal Centers for Disease Control and Prevention;~~

~~(b) The cost of the reporting system for state and local health departments;~~

~~(c) The reporting system's effect on disease control activities;~~

~~(d) The impact of HIV reporting on HIV testing among persons at increased risk of HIV infection; and~~

~~(e) The availability of anonymous HIV testing in the state.~~

~~(12)~~)) (9) The state health officer ((~~must~~)) shall provide a report to the state board of health if federal policy no longer requires that HIV surveillance systems be name-based.

AMENDATORY SECTION (Amending WSR 00-23-120, filed 11/22/00, effective 12/23/00)

WAC 246-101-640 Special condition—Birth defects. The department shall enter into a data sharing agreement with the office of the superintendent of public instruction (the superintendent) to access data from databases maintained by the superintendent containing student health information for the purpose of identifying cases of autism or other conditions of public health interest.

PART VII: NOTIFIABLE CONDITIONS—DEPARTMENT OF LABOR AND INDUSTRIES

AMENDATORY SECTION (Amending WSR 00-23-120, filed 11/22/00, effective 12/23/00)

WAC 246-101-705 Duties ((~~of the~~))—Department of labor and industries. (1) The department of labor and industries shall:

(a) Be responsible for the investigation of cases identified as notifiable to the department of labor and industries under this chapter;

(b) Provide consultation and technical assistance to local health ((~~departments~~)) jurisdictions and the department investigating ((~~notifiable conditions reports~~)) cases;

(((~~(b)~~))) (c) Upon request, provide consultation and technical assistance to health care providers, laboratories, health care facilities, and others required to ((~~make notifications to public health authorities of notifiable conditions upon request~~)) notify and cooperate with public health authorities under this chapter;

(((~~(c)~~))) (d) Provide technical assistance to businesses and labor organizations for understanding the use of notifiable conditions data collected and analyzed by the department of labor and industries; and

(((~~(d)~~))) (e) Develop routine data dissemination mechanisms that describe and analyze notifiable conditions case investigations and data. These may include annual and monthly reports and other mechanisms for data dissemination as developed by the department of labor and industries.

(2) The department of labor and industries may:

(a) Receive data through ((~~any~~)) cooperative ((~~relationship~~)) agreement negotiated by the department of labor and industries and ((~~any~~)) a health care provider, laboratory, or health care facility;

(b) Receive health information, demographic information, and infectious or noninfectious condition information in addition to that required under this chapter from health care providers and health care facilities.

(3) When the department of labor and industries receives information under this section, the department of labor and industries shall handle the information under the requirements of WAC 246-101-710.

AMENDATORY SECTION (Amending WSR 00-23-120, filed 11/22/00, effective 12/23/00)

WAC 246-101-710 Handling of ((~~case reports and medical information~~)) confidential information—Department of labor and industries. (1) ((~~The department of labor and industries shall establish and maintain confidentiality procedures related to employee handling of all reports of cases and suspected cases, prohibiting disclosure of report information identifying an individual case or suspected cases except:~~

~~(a) To employees of the local health department, the department, or other official agencies needing to know for the purpose of administering public health laws and these regulations; and~~

~~(b) To health care providers, specific designees of health care facilities, laboratory directors, and others for the purpose of collecting additional information about a case or suspected case as required for occupational condition prevention and control.~~

~~(2)~~)) All records and specimens related to a case that contain or are accompanied by patient identifying information are confidential. Patient identifying information includes information that can directly or indirectly identify a patient.

(2) The director of the department of labor and industries and department of labor and industries employees shall maintain the confidentiality of health information consistent with chapter 70.02 RCW and RCW 42.56.360(2).

(3) The director of the department of labor and industries shall ((~~require and maintain signed confidentiality agreements with~~)):

(a) Require all employees, contractors, and others with access to ((~~identifying~~)) health information ((~~related to a case or suspected case of a person diagnosed with a notifiable condition. Such agreements will be renewed at least annually and include reference to criminal and civil penalties for violation of chapter 70.02 RCW, other chapters of pertinent state law, and other administrative actions that may be taken by the department of labor and industries.~~

~~(3) The department of labor and industries may release statistical summaries and epidemiological studies based on individual case reports if no individual is identified or identifiable~~)), to sign confidentiality agreements;

(b) Retain signed confidentiality agreements;

(c) Reference in confidentiality agreements the administrative actions that may be taken by the department of labor and industries if the confidentiality agreement is violated; and

(d) Renew confidentiality agreements at least annually.

AMENDATORY SECTION (Amending WSR 00-23-120, filed 11/22/00, effective 12/23/00)

WAC 246-101-715 ((~~Requirements for~~)) Data dissemination and notification—Department of labor and industries. The department of labor and industries shall:

(1) Distribute periodic epidemiological summary reports and an annual review of public health issues to local health officers ((~~and~~)), local health ((~~departments~~)) jurisdictions, and the department.

(2) Make available case investigation documentation for notifiable conditions reported directly to the department of labor and industries, data necessary to conduct case investigations, or epidemiological summaries to local health officers or ((~~their designees upon execution of a data sharing agreement~~)) the department within two business days of a request.

AMENDATORY SECTION (Amending WSR 00-23-120, filed 11/22/00, effective 12/23/00)

WAC 246-101-730 Special condition—Hospitalized burns. The department of labor and industries shall maintain a surveillance system for monitoring hospitalized burn((~~s~~)) patients that may include:

(1) Development of a sentinel network of burn treatment centers and hospitals to provide information regarding hospitalized burn((~~s~~)) patients; and

(2) Sample checks with health care providers((~~, clinics,~~)) and ((~~hospitals~~)) health care facilities regarding hospitalized burn((~~s~~)) patients.

PART VIII: NOTIFIABLE CONDITIONS—DEPARTMENT OF AGRICULTURE

NEW SECTION

WAC 246-101-805 Duties—Department of agriculture. (1) For the purposes of this section, "new, emerging, or unusual animal diseases or disease clusters with potential public health significance" means zoonotic or potentially zoonotic diseases in animals that have never or rarely been observed in Washington state (new or emerging); or appear in a new species or show evidence of higher pathogenicity than expected (unusual); or appear in a higher than expected number of animals clustered in time or space (cluster).

(2) The department of agriculture shall:

(a) Submit an individual case report for each animal case of a condition identified in Table Agriculture-1 to the department immediately upon being notified of the animal case using secure electronic data transmission under this table and this chapter.

(b) Call the department and confirm receipt immediately after submitting a case report for the following conditions:

(i) Anthrax (*Bacillus anthracis* or *Bacillus cereus* biovar *anthracis*);

(ii) Influenza virus in swine, influenza H5 and H7 (avian);

(iii) Livestock exposed to toxic substances which may threaten public health;

(iv) Plague (*Yersinia pestis*);

(v) Rabies (suspected human or animal);

(vi) Transmissible Spongiform Encephalopathy; and

(vii) Tularemia (*Francisella tularensis*).

Table Agriculture-1 (Conditions Notifiable by the Department of Agriculture)

Notifiable Condition (Agent)
Anthrax (*Bacillus anthracis*or *B. cereus* biovar *anthracis*)
Arboviral Diseases California serogroup Chikungunya Dengue Eastern equine encephalitis Japanese encephalitis La Crosse encephalitis Powassan St. Louis encephalitis Western equine encephalitis West Nile virus Zika
Brucellosis (*Brucella* species)
Coccidioidomycosis (*Coccidioides* species)
Cryptococcus gattii or undifferentiated *Cryptococcus* species (i.e., *Cryptococcus* not identified as C. *neoformans*)
Cysticercosis (*Taenia solium*)
Echinococcosis (*Echinococcus* species)
Ehrlichiosis (*Ehrlichia* species)
Glanders (*Burkholderia mallei*)

Notifiable Condition (Agent)
Influenza virus in swine, influenza H5 and H7 (avian)
Leptospirosis (*Leptospira* species)
Livestock exposed to toxic substances which may threaten public health
Psittacosis (*Chlamydia psittaci*)
Plague (*Yersinia pestis*)
Q Fever (*Coxiella burnettii*)
Rabies (suspected human or animal)
Shiga toxin-producing *E. coli* infections/enterohemorrhagic *E. coli* infections
Transmissible Spongiform Encephalopathy
Trichinosis (*Trichinella spiralis*)
Tuberculosis
Tularemia (*Francisella tularensis*)
Vancomycin-resistant (*Staphylococcus aureus*)
Zoonotic Viral Hemorrhagic Fever
New, emerging, or unusual animal diseases or disease clusters with potential public health significance.

(3) The department of agriculture may provide additional health information, demographic information, or infectious or noninfectious condition information than is required under this chapter to the department, local health jurisdiction, or both when it determines that the additional information will aid the public health authority in protecting and improving the public's health through prevention and control of infectious and noninfectious conditions.

(4) When the department of agriculture submits information under subsection (3) of this section, they shall submit the information using secure electronic data transmission.

(5) The department shall:

(a) Consult with the department of agriculture on all animal cases; and

(b) Notify the local health jurisdiction of animal cases submitted to the department.

NEW SECTION

WAC 246-101-810 Content of case reports—Department of agriculture. (1) The state department of agriculture shall provide the following information for each animal case required under WAC 246-101-805:

(a) Animal species;

(b) Animal county of current residence;

(c) Diagnosis or suspected diagnosis of the condition;

(d) Contact name;

(e) Contact address;

(f) Contact telephone number;

(g) Pertinent laboratory data, if available; and

(h) Other information of public health significance collected under chapter 16-70 WAC.

(2) The local health officer or state health officer may request additional information of epidemiological or public health value when conducting a case investigation or for control of a notifiable condition.

(3) The state health officer and local health officer shall handle all information received under this chapter including, but not limited to, information collected under this subsection and WAC 246-101-805 and information collected during case investigations or for investigation or control of a notifiable condition, consistent with WAC 246-101-515, 246-101-610, and RCW 42.56.380.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 246-101-001	Provisions of general applicability.
WAC 246-101-301	Notifiable conditions and health care facilities.
WAC 246-101-305	Duties of the health care facility.
WAC 246-101-310	Means of notification.
WAC 246-101-315	Content of notifications.
WAC 246-101-320	Handling of case reports and medical information.
WAC 246-101-401	Notifiable conditions and the responsibilities and duties of others.
WAC 246-101-501	Notifiable conditions and local health departments.
WAC 246-101-601	Notifiable conditions and the department of health.
WAC 246-101-620	Requirements for notification to the department of labor and industries.
WAC 246-101-625	Content of notifications to the department of labor and industries.
WAC 246-101-701	Notifiable conditions and the department of labor and industries.
WAC 246-101-720	Requirements for notification to local health departments.

WSR 20-13-063
PROPOSED RULES
HEALTH CARE AUTHORITY

[Filed June 15, 2020, 4:18 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 20-06-042.

Title of Rule and Other Identifying Information: WAC 182-524-0100 General, 182-524-0200 Definitions, and 182-524-0275 Eligibility—COFA Islander dental care coverage (new).

Hearing Location(s): On July 21, 2020, at 10:00 a.m.

As more counties move into Phase 2 of the Governor's Safe Start plan, it is yet unknown whether by the date of this public hearing restrictions of meeting in public places will be eased. Therefore, this hearing is being held virtually only. This will not be an in-person hearing and there is not a physical location available.

You must register for this public hearing on July 21, 2020, 10:00 a.m. PDT at https://attendee.gotowebinar.com/register/6074456904428252685.

After registering, you will receive a confirmation email containing information about joining the webinar.

Date of Intended Adoption: Not sooner than July 22, 2020.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, by July 21, 2020.

Assistance for Persons with Disabilities: Contact Amber Lougheed, phone 360-725-1349, fax 360-586-9727, telecommunications relay services 711, email amber.lougheed@hca.wa.gov, by July 10, 2020.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The agency is creating a new section within chapter 182-524 WAC to implement RCW 74.09.719, which provides dental services for compact of free association (COFA) Islanders and revising other sections as necessary.

Reasons Supporting Proposal: See purpose.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Statute Being Implemented: RCW 74.09.719.

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

Name of Proponent: Health care authority (HCA), governmental.

Name of Agency Personnel Responsible for Drafting: Michael Williams, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-1346; Implementation and Enforcement: Ariel Pyrtek, P.O. Box 45505, Olympia, WA 98504-2716, 360-725-1919.

A school district fiscal impact statement is not required under RCW 28A.305.135.

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

The proposed rule does not impose more-than-minor costs on businesses. Following is a summary of the agency's analysis showing how costs were calculated. The proposed rules are regarding eligibility and do not impose any costs on businesses.

June 15, 2020
Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 19-11-082, filed 5/17/19, effective 6/17/19)

WAC 182-524-0100 General. (1) Compact of Free Association (COFA) islander health care ((~~is a~~)) and COFA islander dental care are state-funded programs administered by the health care authority (the agency) to pay the monthly premiums and out-of-pocket expenses for silver level qualified health plans or qualified dental plans for eligible COFA islanders.

(2) For the purpose of this chapter, "our," "us," and "we" refer to the agency or the agency's designee and "you" refers to the applicant for, or recipient of, COFA islander health care.

(3) You have the right to appeal any adverse agency action regarding COFA islander health care or COFA islander dental care as described in chapter 182-526 WAC. For coordinated appeals with the Washington health benefit exchange, as described under WAC 182-526-0102, we treat appeals made to either the Washington health benefit exchange or us as filed on the same day. You will not have to submit any information that you have previously submitted to either the Washington health benefit exchange or us.

AMENDATORY SECTION (Amending WSR 19-11-082, filed 5/17/19, effective 6/17/19)

WAC 182-524-0200 Definitions. This section defines terms used in this chapter. See chapter 182-500 WAC for additional definitions.

"Advance premium tax credit (APTC)" - A tax credit taken in advance to lower a monthly health insurance payment (or premium).

"COFA islander" - A person who is a citizen of the Federated States of Micronesia, the Republic of the Marshall Islands, or the Republic of Palau.

"COFA islander dental care" - An agency-administered program that pays the premium and out-of-pocket costs for a stand-alone dental plan for eligible COFA islanders.

"COFA islander health care" - An agency-administered program that pays the premium and out-of-pocket costs for a silver level qualified health plan for eligible COFA islanders.

"Compact of Free Association (COFA)" - A legal agreement between the government of the United States and the governments of the Federated States of Micronesia (U.S. Pub. L. 108-188); the Republic of the Marshall Islands (U.S.

Pub. L. 108-188); and the Republic of Palau (U.S. Pub. L. 99-658).

"Cost-sharing funds" - Agency-provided funds for out-of-pocket costs.

"Out-of-pocket costs" - Copayments, coinsurance, deductibles, and other cost-sharing requirements imposed under a qualified health plan for services, pharmaceuticals, devices, and other health benefits covered by the plan and rendered as in-network. Excludes premiums, balance billing amounts for out-of-network providers, and spending for non-covered services.

"Premium cost" - A person's premium for a qualified health plan, minus the amount of the person's advanced premium tax credit.

"Qualified dental plan (QDP)" - A stand-alone dental plan offered by the Washington health benefit exchange (HBE). For a definition of stand-alone dental plan, see WAC 284-43-6020.

"Qualified dental plan - Noncovered services" - In-network services that are not covered by the QDP, and are consistent with but do not exceed benefits covered under the agency's adult dental program described in chapter 182-535 WAC.

"Silver level qualified health plan (QHP)" - Silver level indicates the category of a qualified health plan (QHP) offered by the Washington health benefit exchange (HBE). For a definition of QHP, see WAC 182-500-0090.

NEW SECTION

WAC 182-524-0275 Eligibility—COFA islander dental care coverage. You apply for COFA islander dental care the same way you would apply for COFA islander health care as described in WAC 182-524-0250.

(1) To be eligible for state-funded COFA islander dental care, you must enroll in a qualified dental plan (QDP) through the Washington health benefit exchange (HBE) during open enrollment or when you qualify for a special enrollment period as described in 45 C.F.R. 155.410 and 45 C.F.R. 420.

(2) You are eligible for COFA islander dental care administered by us no earlier than January 1, 2021, if you enroll in a QDP and:

(a) Meet the requirements of COFA islander health care as described in WAC 182-524-0300 (1)(a) through (f); or

(b) Are enrolled in medicare, meet the requirements as described in WAC 182-524-0300 (1)(a) and (c) and:

(i) Are a resident as described in WAC 182-524-0400 (1) through (3).

(ii) You can be temporarily out-of-state and remain on COFA islander dental care if you:

(A) Intend to return once the purpose of your absence concludes; and

(B) Meet the eligibility requirements described in this section.

(3) Eligibility for COFA islander dental care under subsection (2) of this section is subject to the availability of amounts appropriated for the program as described in WAC 182-524-0300(2).

(4) Your COFA islander dental care begins the first day of the month your QDP coverage begins and you meet the other eligibility requirements described in subsection (2) of this section.

(5) We will pay for your premiums, QDP out-of-pocket costs and QDP-noncovered services the same way we pay your premiums and out-of-pocket costs for COFA islander health care as described in WAC 182-524-0600. We may require authorization for payment for QDP-noncovered services.

(6) We will not pay for expenses incurred by people not covered under COFA islander dental care or services excluded under the medicaid dental program as described in WAC 182-535-1100.

(7) We will send you notices and letters according to the same provisions and requirements as the letters we send regarding COFA islander health care as described in WAC 182-524-0500.

(8) We will terminate your COFA islander dental care if you:

(a) No longer meet the eligibility criteria described in subsection (2) of this section;

(b) Request termination;

(c) Perform an act, practice, or omission that constitutes fraud and your insurer rescinds your policy;

(d) Use your COFA islander dental care cost-sharing funds to pay for anything other than:

(i) Out-of-pocket costs for dental coverage under your QDP; or

(ii) Authorized QDP-noncovered services.

(9) We will reinstate your COFA islander dental care if you are:

(a) Terminated in error; or

(b) Successful in your appeal of a termination.

(10) If you report a change that makes you eligible for COFA islander dental care, your sponsorship begins either:

(a) The first day of the following month, if the change was reported on or before the fifteenth of the month; or

(b) The first day of the month after the following month, if the change was reported after the fifteenth of the month.

(11) Your COFA islander dental care ends the day your enrollment in a silver level QHP ends or the last day of the month your COFA islander dental care eligibility ends, whichever is earlier.

WSR 20-13-069
PROPOSED RULES
HEALTH CARE AUTHORITY
(School Employees Benefits Board)

[Admin # 2020-04—Filed June 16, 2020, 8:02 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 20-09-119.

Title of Rule and Other Identifying Information: **The following sections in chapter 182-30 WAC are revised, removed, or new:** WAC 182-30-020 Definitions, 182-30-040 Premium payments and premium refunds, 182-30-050

What are the requirements regarding premium surcharges?, 182-30-070 The employer contribution is set by the health care authority (HCA) and paid to the HCA for all eligible school employees, 182-30-075 Subscriber address requirements, 182-30-080 When must a newly eligible school employee, or a school employee who regains eligibility for the employer contribution, elect school employees benefits board (SEBB) benefits and complete required forms?, 182-30-081 (removed) School employees benefits board (SEBB) first annual open enrollment, 182-30-085 What happens if my health plan becomes unavailable due to a change in contracted service area or eligibility for medicare?, 182-30-090 When may a subscriber change health plans?, 182-30-100 When may a school employee enroll, or revoke an election and make a new election under the premium payment plan, medical flexible spending arrangement (FSA), or dependent care assistance program (DCAP)?, and 182-30-140 (new) What is the process for school districts to offer optional benefits?

The following sections in chapter 182-31 WAC are revised or removed: WAC 182-31-020 Definitions, 182-31-030 What are the obligations of a school employees benefits board (SEBB) organization in the application of school employee eligibility?, 182-31-050 When does eligibility for the employer contribution for school employees benefits board (SEBB) benefits end?, 182-31-070 Is dual enrollment in school employees benefits board (SEBB) prohibited?, 182-31-080 When may a school employee waive enrollment in school employees benefits board (SEBB) medical and when may they enroll in SEBB medical after having waived enrollment?, 182-31-090 When is an enrollee eligible to continue school employees benefits board (SEBB) benefits under Consolidated Omnibus Budget Reconciliation Act (COBRA)?, 182-31-091 (removed) School employees benefits boards (SEBB) continuation coverage for school employees and their dependents who are not eligible for SEBB benefits as of January 1, 2020, and for dependents who were already on a SEBB organization's continuation coverage as of December 31, 2019?, 182-31-100 What options for continuation coverage are available to school employees and their dependents during certain types of leave or when employment ends due to a layoff?, 182-31-110 What options are available if a school employee is approved for the federal Family and Medical Leave Act (FMLA) or the paid family and medical leave program?, 182-31-120 What options for continuation coverage are available to school employees during their appeal of a grievance?, 182-31-130 What options for continuation coverage are available to dependents who cease to meet the eligibility criteria as described in WAC 182-31-140 or 182-30-130?, 182-31-135 Where may school employee survivors go for additional coverage options?, 182-31-140 Who are eligible dependents?, 182-31-150 When may subscribers enroll or remove eligible dependents?, 182-31-160 National Medical Support Notice (NMSN), and 182-31-190 School employees benefits board (SEBB) wellness incentive program eligibility and procedural requirements.

The following sections in chapter 182-32 WAC are revised: WAC 182-32-010 Purpose, 182-32-020 Definitions, 182-32-058 Service or serve, 182-32-066 Burden of proof, standard of proof, and presumptions, 182-32-120 Computation of time, 182-32-130 Index of significant decisions, 182-32-2010 Appealing a decision regarding school employees benefits board (SEBB) eligibility, enrollment, premium payments, premium surcharges, a wellness incentive, or the administration of benefits, 182-32-2020 Appealing a decision made by a school employees benefits board (SEBB) organization about eligibility, premium surcharges, or enrollment in benefits, 182-32-2030 Appealing a school employees benefits board (SEBB) program decision regarding eligibility, enrollment, premium payments, premium surcharges, and a SEBB wellness incentive, 182-32-2040 How can a subscriber appeal a decision regarding the administration of wellness incentive program requirements?, 182-32-2050 How can a school employee appeal a decision regarding the administration of benefits offered under the salary reduction plan?, 182-32-2085 Continuances, 182-32-2090 Initial order, 182-32-2100 How to request a review of an initial order resulting from a brief adjudicative proceeding, 182-32-2110 Final order, 182-32-2120 Request for reconsideration, 182-32-2140 Presiding officer—Designation and authority, 182-32-2150 Review officer or officers—Designation and authority, 182-32-2160 Conversion of a brief adjudicative proceeding to a formal administrative hearing, 182-32-3000 Formal administrative hearings, 182-32-3015 Hearing officers—Assignment, motions of prejudice, and disqualification, 182-32-3100 Rescheduling and continuances for formal administrative hearings, 182-32-3120 Dispositive motions, 182-32-3140 Orders of dismissal—Reinstating a formal administrative hearing after an order of dismissal, 182-32-3170 Final order deadline—Required information, 182-32-3180 Request for reconsideration and response—Process, and 182-32-3190 Decisions on requests for reconsideration.

Hearing Location(s): On July 21, 2020, at 10:00 a.m.

As more counties move into Phase 2 of the Governor's Safe Start plan, it is yet unknown whether by the date of this public hearing restrictions of meeting in public places will be eased. Therefore, this hearing is being held virtually only. This will not be an in-person hearing and there is not a physical location available.

You must register for this public hearing on July 21, 2020, 10:00 a.m. PDT at https://attendee.gotowebinar.com/register/6074456904428252685. After registering, you will receive a confirmation email containing information about joining the webinar.

Date of Intended Adoption: Not sooner than July 22, 2020.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, by July 21, 2020.

Assistance for Persons with Disabilities: Contact Amber Lougheed, phone 360-725-1349, fax 360-586-9727, telecommunications relay services 711, email amber.lougheed@hca.wa.gov, by July 10, 2020.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The purpose of this proposal is to create new rules and to amend some of the existing rules to support the school employee benefits board (SEBB) program.

1. Statutory changes:

- Amended WAC 182-30-070 to include Paid Family and Medical Leave Program for the employer contribution to be maintained when a school employee is on such leave and for enrolled dependents;
- Created WAC 182-30-140 to establish a process for school districts to offer optional benefits based on HB 2458.

2. Make technical amendments:

- Amended chapters 182-30, 182-31, and 182-32 WAC with global changes to update the use of health plan, insurance coverage, benefits, and specific benefits;
- Within the definitions sections of chapters 182-30, 182-31, and 182-32 WAC:
  - Amended the definition of "Continuation coverage" to allow continuation of benefits instead of health plan coverage;
  - Amended the definition of "Employer-based group health plan" and revising it to "Employer-group medical" within WAC 182-32-020, added the new definition of "Employer-based group medical." within chapters 182-30 and 182-31 WAC;
  - Amended the definition of "Health plan" by replacing the word "SEBB" with "board";
  - Amended the definition of "Life insurance" to align all definitions within all three chapters for consistency;
  - Amended the definition of "LTD insurance" by spelling out the acronym;
  - Removed the definition of "Public employees benefits board" or "PEBB" and replaced it with a new definition of "PEBB"; and
  - Amended the definition of "SEBB" by removing the reference to RCW 41.05.740.
- Added the definition of "Board" in WAC 182-31-020 and 182-32-020.
- Aligned the definition of "Calendar days" or "days" in WAC 182-31-020 and 182-32-020.
- Amended WAC 182-30-020 to add a definition of "Benefits administrator."
- Amended WAC 182-32-020 the definition of "Business days" to include "state" when referencing legal holidays to align with statute.
- Amended WAC 182-30-040 to clarify insurance coverage for premiums and applicable premium surcharges, updated WAC citations, clarified where premium payments go to, and clarified when a subscriber's account becomes delinquent for subscribers that are not eligible for the employer contribution.
- Amended WAC 182-30-050 to clarify the exception regarding waiving and not incurring a surcharge when a school employee's spouse or state registered domestic partner is eligible for SEBB medical.
- Amended WAC 182-30-070 to clarify insurance instead of benefits and to require school employees on Paid Family and Medical Leave keep the employer contribution.
- Amended WAC 182-30-075 to align language with the SEBB appeal rules and add acronyms.
- Within WAC 182-30-080:
  - Updated internal references;
  - Clarified a school employee's participation in the salary plan ends when they lose eligibility for the employer contribution;
  - Clarified that forms may be submitted to the contracted vendor;
  - Clarified requirement to apply for accidental death and dismemberment insurance;
  - Correctly named the surcharges;
  - Improved readability;
  - Clarified requirements for school employees who continued paying for supplemental life insurance; and
  - Clarified enrollment for returning school employees who do not make elections.
- Rescinded WAC 182-30-081 addressing the requirements of the first SEBB annual open enrollment period.
- Amended WAC 182-30-085 to provide clarity on what happens when a health plan becomes unavailable or a school employee loses eligibility for a health plan.
- Within WAC 182-30-090:
  - Amended this section to clarify eligibility regarding special open enrollment by including two WAC references;
  - Clarified that gaining initial eligibility or regaining eligibility does not create a special open enrollment;
  - Added information about timing of benefits for extended or disabled dependents; and
  - Updated language in medicaid, medicare, and state children's health insurance program special open enrollment for clarity.
- Amended WAC 182-30-100 to clarify that either a school employee or their dependent enrolls in coverage or loses coverage under medicare, updated language in medicaid, medicare, and state children's health insurance program special open enrollments for clarity, and updated internal references in the note. Clarified school employees, not subscribers, may make changes and that medical plans may not be changed unless the change aligns with the cafeteria plan rules and to clarify for a subscriber who has a change in employment from a SEBB organization to a public school district that straddles county lines or is in a county that borders Idaho or Oregon.
- Amended WAC 182-31-030 to address school employees who receive a notice in writing of eligibility must have no less than ten calendar days to elect coverage and technical corrections to use the updated definitions.
- Amended WAC 182-31-050 to clarify that benefits will be termed the last day of the month premiums were deducted to prevent a rescission, and school employee premiums must be refunded if deducted in advance when no longer eligible.
- Amended WAC 182-31-070 to clarify medical, dental, and vision coverage is limited to a single enrollment per individual and clarified that an eligible school employee may only waive SEBB medical and enroll as a dependent under the medical plan of their spouse, state registered domestic partner, or parent.

- Amended WAC 182-31-080 to clarify returning from waiving SEBB medical in the events regarding medicaid and state children's health insurance program and changed "entitled to" to "enrolled in" for special open enrollment events regarding medicaid and state children's health insurance program, and updated language in medicaid, medicare, and state children's health insurance program special open enrollments for clarity.
- Amended WAC 182-31-090 to clarify that a school employee or their dependent may continue SEBB medical, dental, or vision under Consolidated Omnibus Budget Reconciliation Act (COBRA) and clarified a subscriber's state registered domestic partner and their children may continue SEBB medical, dental, or vision on the same terms and conditions as a spouse and other eligible dependents, added specific reference to the premium payment rule, and made minor changes for readability.
- Rescinded WAC 182-31-091 that describes SEBB continuation coverage for school employees and their dependents not eligible for SEBB benefits only applied during go-live of the SEBB program.
- Amended WAC 182-31-100 to clarify continuation coverage regarding life and accidental death and dismemberment insurance including supplemental coverages, clarified that "coverage" not "benefits" may be continued, made changes for readability, and updated references.
- Amended WAC 182-31-110 to clarify, add details, and update references about the Paid Family and Medical Leave Program and the employer contribution, and removed language to no longer allow insurance coverage to be terminated for non-payment when a school employee is on Family Medical and Leave Act or Paid Family and Medical Leave.
- Amended WAC 182-31-120 to add a "court" as an entity to review a dismissal action to the list of decision makers, specify coverage "terminates" rather than "ends," and specify school employees "may enroll in" supplemental coverage rather than having coverage "restored" if retroactive premiums are not received.
- Within WAC 182-31-130:
  - Amended this section to clarify the dependent's first premium payment and applicable premium surcharges due date based on the applicable citations, specified that medical, dental, and vision premiums and applicable premium surcharges must be made to HCA;
  - Clarified that a school employee or their dependent may continue SEBB medical, dental, or vision under COBRA and clarified a subscriber's state registered domestic partner and their children may continue SEBB medical, dental, or vision on the same terms and conditions as a spouse and other eligible dependents under COBRA, and added specific reference to the premium payment rule.
- Amended WAC 182-31-140 to clarify that a dependent will not be enrolled in a health plan coverage if the SEBB program or SEBB organization is unable to verify eligibility within the timelines, removed specific language regarding providing notice of loss of eligibility and noted appropriate reference. In addition, clarified that verification will require renewed proof for disability and dependence for a child twenty-six or older.
- Within WAC 182-31-150:
  - Clarified the effective dates of insurance coverage and supplemental dependent life and AD&D insurance;
  - Removed language regarding newborn child having an effective date for supplemental dependent life or AD&D insurance on the date the child becomes fourteen days old;
  - Included new language concerning a newborn child regarding supplemental coverages, effective dates, and requirements;
  - Included new language regarding a National Medical Support Notice which allows a subscriber to add or remove dependents, and specified for clarity the enrollment and removal requirements for supplemental dependent life and AD&D insurance; and
  - Clarified enrollment in medicaid or a state children's health insurance program.
- Amended WAC 182-31-160 clarifying when a dependent already enrolled may be removed from health plan coverage regarding National Medical Support Notice.
- Amended WAC 182-31-190 to remove language regarding the $50 wellness incentive as a reduction for plan year 2020, clarified that subscribers must be eligible to complete the SEBB wellness incentive requirements, and clarified that the subscriber has to be enrolled in a SEBB medical plan the year the incentive applies. Additionally, changed "SEBB Program" to "contracted vendor" regarding different means to earn the incentive.
- Amended chapter 182-32 WAC with global fixes throughout replacing the word "shall" to "must" for consistency.
- Amended WAC 182-32-058 to clarify that a party may prove a service from a signed affidavit of mailing or certificate of the service.
- Amended WAC 182-32-066 to clarify a reference to a standard of proof.
- Amended WAC 182-32-120 to clarify state legal holiday.
- Amended WAC 182-32-130 to clarify that a final order is what is relied upon, not a decision.
- Amended WAC 182-32-2020 to clarify a timeline for appeals when the SEBB organization fails to render a decision within thirty days.
- Amended WAC 182-32-2030 to clarify when failing to request a brief adjudicative proceeding that the language in this section maintains consistency with other sections.
- Amended WAC 182-32-2040 to clarify language regarding the subscriber failing to timely request for a brief adjudicative proceeding for the wellness incentive program and maintain consistency with other sections within the chapter.
- Amended WAC 182-32-2050 to clarify a timeline for appeals when the SEBB organization fails to render a decision within thirty days.

- Amended WAC 182-32-2085 to clarify when they request for a continuance, they can on their own.
- Amended WAC 182-32-2100 to clarify the initial order by maintaining consistency with other sections within chapter 182-32 WAC.
- Amended WAC 182-32-2110 to make a technical correction and narrowed down the provision of the final order.
- Amended WAC 182-32-2120 to clarify that an appellant is not petitioning for a reconsideration.
- Amended WAC 182-32-2150 to clarify that a brief adjudicative proceeding can be converted into a formal administrative hearing not referred.
- Amended WAC 182-32-2160 to clarify that a representative, the authority, or presiding officer or review officer or officers can convert a brief adjudicative proceeding on their own.
- Amended WAC 182-32-3015 to clarify that the hearing officer must serve the order no later than seven days after receiving the petition for disqualification.
- Amended WAC 182-32-3100 to specify rescheduling the formal administrative hearing and removed the requirement to immediately telephone all other parties in the event of a continuance.
- Amended WAC 182-32-3120 to update references.
- Amended WAC 182-32-3140 to update "good cause" requirements, update references, and make a minor change for readability.
- Amended WAC 182-32-3170 to clarify that a final order is the authority's final decision by removing the redundancy as it is a defined term.
- Amended WAC 182-32-3180 to clarify what new information may be introduced.
- Amended WAC 182-32-3190 by replacing "dispose of" with "decide."

3. Amend rules to improve administration of the SEBB program:

- Amended WAC 182-32-010 to remove the acronym.
- Amended WAC 182-32-020 to add quotations to the definition of "contracted vendor," clarified that "disability insurance" applied to school employees, changed "employer-based group health plan" to "employer-based group medical," updated the definition of "file" to refer to a defined term, and removed acronyms in the definition of "salary reduction plan."
- Amended WAC 182-32-3000 referencing Part III of chapter 182-32 WAC to maintain consistency and improve readability.

Reasons Supporting Proposal: See purpose statement.

Statutory Authority for Adoption: RCW 41.05.021 and 41.05.160.

Statute Being Implemented: HB 2458, 2020 regular session.

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

Name of Proponent: Health care authority (HCA), governmental.

Name of Agency Personnel Responsible for Drafting: Rob Parkman, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-0883; Implementation: Barbara Scott, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-0830; and Enforcement: Scott Palafox, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-1858.

A school district fiscal impact statement is not required under RCW 28A.305.135.

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

The proposed rule does not impose more-than-minor costs on businesses. Following is a summary of the agency's analysis showing how costs were calculated. These rules do not apply to small businesses.

June 16, 2020
Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-30-020 Definitions. The following definitions apply throughout this chapter unless the context clearly indicates another meaning:

"Accidental death and dismemberment insurance" or "AD&D" means basic accidental death and dismemberment (AD&D) insurance paid for by the SEBB organization, as well as supplemental accidental death and dismemberment insurance offered to and paid for by school employees for themselves and their dependents.

"Annual open enrollment" means an annual event set aside for a period of time by the HCA when subscribers may make changes to their health plan enrollment and salary reduction elections for the following plan year. During the annual open enrollment, subscribers may transfer from one health plan to another, enroll or remove dependents from coverage, enroll in coverage, or waive enrollment in SEBB medical. School employees participating in the salary reduction plan may enroll in or change their election under the dependent care assistance program (DCAP), or the medical flexible spending arrangement (FSA). They may also enroll in or opt out of the premium payment plan.

"Authority" or "HCA" means the Washington state health care authority.

"Benefits administrator" means any person or persons designated by the SEBB organization that trains, communicates, and interacts with school employees as the subject matter expert for eligibility, enrollment, and appeals for SEBB benefits.

"Board" means the school employees benefits board established under provisions of RCW 41.05.740.

"Calendar days" or "days" means all days including Saturdays, Sundays, and all ((~~legal~~)) state legal holidays as set forth in RCW 1.16.050.

"Consolidated Omnibus Budget Reconciliation Act" or "COBRA" means continuation coverage as administered under 42 U.S.C. Secs. 300bb-1 through 300bb-8.

"Continuation coverage" means the temporary continuation of ((~~health plan coverage~~)) SEBB benefits available to enrollees under the Consolidated Omnibus Budget Reconcil-

iation Act (COBRA), 42 U.S.C. Secs. 300bb-1 through 300bb-8, the Uniformed Services Employment and Reemployment Rights Act (USERRA), 38 U.S.C. Secs. 4301 through 4335, or SEBB policies.

"Contracted vendor" means any person, persons, or entity under contract or agreement with the HCA to provide goods or services for the provision or administration of SEBB benefits. The term "contracted vendor" includes subcontractors of the HCA and subcontractors of any person, persons, or entity under contract or agreement with the HCA that provide goods or services for the provision or administration of SEBB benefits.

"Dependent" means a person who meets eligibility requirements in WAC 182-31-140.

"Dependent care assistance program" or "DCAP" means a benefit plan whereby school employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan under chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 129 or other sections of the Internal Revenue Code.

"Director" means the director of the authority.

"Employer-based group health plan" means group medical, group vision, and group dental related to a current employment relationship. It does not include medical, vision, or dental coverage available to retired employees, individual market medical or dental coverage, or government-sponsored programs such as medicare or medicaid.

"Employer-based group medical" means group medical related to a current employment relationship. It does not include medical coverage available to retired employees, individual market medical coverage, or government-sponsored programs such as medicare or medicaid.

"Employer contribution" means the funding amount paid to the HCA by a school employees benefits board (SEBB) organization for its eligible school employees as described under WAC 182-31-040 or 182-30-130.

"Enrollee" means a person who meets all eligibility requirements defined in chapter 182-31 WAC or WAC 182-30-130, who is enrolled in SEBB benefits, and for whom applicable premium payments have been made.

"Forms" or "form" means both paper forms and forms completed electronically.

"Health plan" means a plan offering medical, vision, dental, or any combination of these coverages, developed by the ((~~SEBB~~)) board and provided by a contracted vendor or self-insured plans administered by the HCA.

"Insignificant shortfall" means a premium balance owed that is less than or equal to the lesser of $50 or ten percent of the premium required by the health plan as described in Treasury Regulation 26 C.F.R. 54.4980B-8.

"Life insurance" means ((~~any~~)) basic life insurance paid for by the SEBB organization, as well as supplemental life insurance offered to and paid for by school employees for themselves and their dependents.

"Long-term disability insurance" or "LTD insurance" ((~~or "long-term disability insurance"~~)) means any basic long-term disability insurance paid for by the SEBB organization and any supplemental long-term disability insurance offered to and paid for by the school employee.

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby eligible school employees may reduce their salary before taxes to pay for medical expenses not reimbursed by insurance as provided in the salary reduction plan established under chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"PEBB" means the public employees benefits board.

"Premium payment plan" means a benefit plan whereby school employees may pay their share of group health plan premiums with pretax dollars as provided in the salary reduction plan under chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"Premium surcharge" means a payment required from a subscriber, in addition to the subscriber's medical premium contribution, due to an enrollee's tobacco use or an enrolled subscriber's spouse or state registered domestic partner choosing not to enroll in their employer-based group medical when:

• The spouse's or state registered domestic partner's share of the medical premium is less than ninety-five percent of the additional cost an employee would be required to pay to enroll a spouse or state registered domestic partner in the public employees benefits board (PEBB) Uniform Medical Plan (UMP) Classic; and

• The benefits have an actuarial value of at least ninety-five percent of the actuarial value of PEBB UMP Classic benefits.

((~~"Public employees benefits board" or "PEBB" means the board established under RCW 41.05.055.~~))

"Salary reduction plan" means a benefit plan whereby school employees may agree to a reduction of salary on a pretax basis to participate in the dependent care assistance program, medical flexible spending arrangement, or premium payment plan offered pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"School employee" means:

• All employees of school districts and charter schools established under chapter 28A.710 RCW;

• Represented employees of educational service districts; and

• Effective January 1, 2024, all employees of educational service districts.

"School employees benefits board organization" or "SEBB organization" means a public school district or educational service district or charter school established under chapter 28A.710 RCW that is required to participate in benefit plans provided by the school employees benefits board.

"School year" means school year as defined in RCW 28A.150.203(11).

"SEBB" means the school employees benefits board ((~~established in RCW 41.05.740~~)).

"SEBB benefits" means one or more insurance coverages or other school employee benefits administered by the SEBB program within the HCA.

"SEBB insurance coverage" means any health plan, life insurance, accidental death and dismemberment insurance, or long-term disability insurance administered as a SEBB benefit.

"SEBB program" means the program within the HCA that administers insurance and other benefits for eligible school employees (as described in WAC 182-31-040 or 182-30-130) and eligible dependents (as described in 182-31-140).

"Special open enrollment" means a period of time when subscribers may make changes to their health plan enrollment and salary reduction elections outside of the annual open enrollment period when specific life events occur. During the special open enrollment subscribers may change health plans and enroll or remove dependents from coverage. Additionally, school employees may enroll in or waive enrollment in SEBB medical. School employees eligible to participate in the salary reductions plan may enroll in or revoke their election under the DCAP, medical FSA, or the premium payment plan and make a new election. For special open enrollment events related to specific SEBB benefits, see WAC 182-30-090, 182-30-100, 182-31-080, and 182-31-150.

"State registered domestic partner" has the same meaning as defined in RCW 26.60.020(1) and substantially equivalent legal unions from other jurisdictions as defined in RCW 26.60.090.

"Subscriber" means the school employee or continuation coverage enrollee who has been determined eligible by the SEBB program or SEBB organization, is enrolled in SEBB benefits, and is the individual to whom the SEBB program and contracted vendors will issue all notices, information, requests, and premium bills on behalf of an enrollee.

"Supplemental coverage" means any life insurance, accidental death and dismemberment (AD&D) insurance coverage, or long-term disability coverage purchased by the school employee in addition to the basic coverage provided by the school employees benefits board (SEBB) organization.

"Tobacco products" means any product made with or derived from tobacco that is intended for human consumption, including any component, part, or accessory of a tobacco product. This includes, but is not limited to, cigars, cigarettes, pipe tobacco, chewing tobacco, snuff, and other tobacco products. It does not include e-cigarettes or United States Food and Drug Administration (FDA) approved quit aids.

"Tobacco use" means any use of tobacco products within the past two months. Tobacco use, however, does not include the religious or ceremonial use of tobacco.

"Waive" means an eligible school employee affirmatively declining enrollment in ((~~a~~)) SEBB ((~~health plan~~)) medical because the school employee is enrolled in other employer-based group medical, a TRICARE plan((~~s~~)), or medicare as allowed under WAC 182-31-080.

"Week" means a seven-day period starting on Sunday and ending on Saturday.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-30-040 Premium payments and premium refunds. School employees benefits board (SEBB) ((~~benefits~~)) insurance coverage premiums and applicable premium surcharges for all subscribers are due as described in this section, except when a SEBB organization is correcting its enrollment error as described in WAC 182-30-060 (4) or (5).

(1) **Premium payments.** SEBB ((~~benefits~~)) insurance coverage premiums and applicable premium surcharges for all subscribers become due the first of the month in which SEBB ((~~benefits are~~)) insurance is effective.

Premiums and applicable premium surcharges are due from the subscriber for the entire month of SEBB ((~~benefits~~)) insurance coverage and will not be prorated during any month.

(a) For subscribers not eligible for the employer contribution that are electing to enroll in continuation coverage as described in WAC 182-31-090, ((~~182-31-091,~~)) 182-31-100, 182-31-120, or 182-31-130, the first premium payment and applicable premium surcharges are due to the health care authority (HCA) or the contracted vendor no later than forty-five days after the election period ends as described within the Washington Administrative Code applicable to the subscriber. Premiums and applicable premium surcharges associated with continuing SEBB medical must be made to the HCA as well as premiums associated with continuing SEBB dental or vision insurance coverage. Premiums associated with life insurance coverage and accidental death and dismemberment (AD&D) coverage must be made to the contracted vendor. Following the first premium payment, premiums and applicable premium surcharges must be paid as premiums become due.

(b) For school employees who are eligible for the employer contribution, premiums and applicable premium surcharges are due to the SEBB organization. If a school employee elects supplemental coverage, the school employee is responsible for payment of premiums from the month the supplemental coverage begins.

(c) Unpaid or underpaid premiums or applicable premium surcharges for all subscribers must be paid, and are due from the SEBB organization, subscriber, or a subscriber's legal representative to the HCA or the contracted vendor. For subscribers not eligible for the employer contribution ((~~or school employees eligible for the employer contribution as described in WAC 182-31-110~~)), monthly premiums or applicable premium surcharges that remain unpaid for thirty days will be considered delinquent. A subscriber is allowed a grace period of thirty days from the date the monthly premiums or applicable premium surcharges become delinquent to pay the unpaid premium balance or applicable premium surcharges. If a ((~~subscriber's~~)) subscriber, who is not eligible for the employer contribution, has monthly premiums or applicable premium surcharges remain unpaid for sixty days from the original due date, the subscriber's SEBB ((~~benefits~~)) insurance coverage will be terminated retroactive to the last day of the month for which the monthly premiums and any applicable premium surcharges were paid. If it is determined by the HCA that payment of the unpaid balance in a lump sum would be considered a hardship, the HCA may develop a reasonable payment plan up to twelve months in duration with the subscriber or the subscriber's legal representative upon request.

(d) Monthly premiums or applicable premium surcharges due from a subscriber who is not eligible for the

employer contribution will be considered unpaid if one of the following occurs:

(i) No payment of premiums or applicable premium surcharges are received by the HCA or the contracted vendor and the monthly premiums or applicable premium surcharges remain unpaid for thirty days; or

(ii) Premium payments or applicable premium surcharges received by the HCA or the contracted vendor are underpaid by an amount greater than an insignificant shortfall and the monthly premiums or applicable premium surcharges remain underpaid for thirty days past the date the monthly premiums or applicable premium surcharges were due.

(2) **Premium refunds.** SEBB ((~~benefits~~)) insurance coverage premiums and applicable premium surcharges will be refunded using the following methods:

(a) When a subscriber submits an enrollment change affecting subscriber or dependent eligibility, HCA may allow up to three months of accounting adjustments. HCA will refund to the individual or the SEBB organization any excess premiums and applicable premium surcharges paid during the three month adjustment period, except as indicated in WAC 182-31-120.

(b) If a SEBB subscriber, dependent, or beneficiary submits a written appeal as described in WAC 182-32-2010, and provides clear and convincing evidence of extraordinary circumstances, such that the subscriber could not timely submit the necessary information to accomplish an allowable enrollment change within sixty days after the event that created a change of premiums, the SEBB director, the SEBB director's designee, or the SEBB appeals unit may:

(i) Approve a refund of premiums and applicable premium surcharges that does not exceed twelve months of premiums; and

(ii) Approve the enrollment change that was originally requested and which forms the basis for the refund.

(c) If a federal government entity determines that an enrollee is retroactively enrolled in coverage (for example, medicare) the subscriber or beneficiary may be eligible for a refund of premiums and applicable premium surcharges paid during the time they were enrolled under the federal program if approved by the SEBB director or the SEBB director's designee.

(d) HCA errors will be corrected by returning all excess premiums and applicable premium surcharges paid by the SEBB organization, subscriber, or beneficiary.

(e) SEBB organization errors will be corrected by returning all excess premiums and applicable premium surcharges paid by the school employee or beneficiary as described in WAC 182-30-060 (4) and (5).

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-30-050 What are the requirements regarding premium surcharges? (1) A subscriber's account will incur a premium surcharge in addition to the subscriber's monthly medical premium, when any enrollee, thirteen years and older, engages in tobacco use.

(a) A subscriber must attest to whether any enrollee, thirteen years and older, enrolled in their school employees benefits board (SEBB) medical engages in tobacco use. The subscriber must attest as described in (a)(i) through (v) of this subsection:

(i) A school employee who is newly eligible or regains eligibility for the employer contribution toward SEBB benefits must complete the required form to enroll in SEBB medical as described in WAC 182-30-080 (1) or (3). The school employee must include their attestation on that form. The school employee must submit the form to their SEBB organization. If the school employee's attestation results in a premium surcharge, it will take effect the same date as SEBB medical begins;

(ii) If there is a change in the tobacco use status of any enrollee, thirteen years and older on the subscriber's SEBB medical, the subscriber must update their attestation on the required form. A school employee must submit the form to their SEBB organization. A subscriber on continuation coverage must submit their updated form to the SEBB program. The attestation change will apply as follows:

• A change that results in a premium surcharge will begin the first day of the month following the status change. If that day is the first of the month, the change to the surcharge begins on that day.

• A change that results in removing the premium surcharge will begin the first day of the month following receipt of the attestation. If that day is the first of the month, the change to the surcharge begins on that day.

(iii) If a subscriber submits the required form to enroll a dependent, thirteen years and older, in SEBB medical as described in WAC 182-31-150, the subscriber must attest for their dependent on the required form. A school employee must submit the form to their SEBB organization. A subscriber on continuation coverage must submit their form to the SEBB program. A change that results in a premium surcharge will take effect the same date as SEBB medical begins;

(iv) An enrollee, thirteen years and older, who elects to continue medical coverage as described in WAC 182-31-090, must provide an attestation on the required form if they have not previously attested as described in (a) of this subsection. The enrollee must submit their form to the SEBB program. An attestation that results in a premium surcharge will take effect the same date as SEBB medical begins; or

(v) A school employee who previously waived SEBB medical must complete the required form to enroll in SEBB medical as described in WAC 182-31-080(3). The school employee must submit their attestation on that form. A school employee must submit the form to their SEBB organization. An attestation that results in a premium surcharge will take effect the same date as SEBB medical begins.

Note: A school employee who waives SEBB medical as described in WAC 182-31-080 is not required to provide an attestation and no premium surcharge will be applied to their account as long as the school employee remains in waived status.

(b) A subscriber's account will incur a premium surcharge when a subscriber fails to attest to the tobacco use status of all enrollees as described in (a) of this subsection.

(c) The SEBB program will provide reasonable alternatives for enrollees who use tobacco products. A subscriber can avoid the tobacco use premium surcharge if the sub-

scriber attests on the required form that all enrollees who use tobacco products enrolled in or accessed one of the applicable reasonable alternatives offered below:

(i) An enrollee who is eighteen years and older and uses tobacco products is currently enrolled in the free tobacco cessation program through their SEBB medical.

(ii) An enrollee who is thirteen through seventeen years old and uses tobacco products accessed the information and resources aimed at teens on the Washington state department of health's website at https://teen.smokefree.gov.

(iii) A subscriber may contact the SEBB program to accommodate a physician's recommendation that addresses an enrollee's use of tobacco products or for information on how to avoid the tobacco use premium surcharge.

(2) A subscriber will incur a premium surcharge, in addition to the subscriber's monthly medical premium, if an enrolled spouse or state registered domestic partner has chosen not to enroll in another employer-based group medical where the spouse's or state registered domestic partner's share of the medical premium is less than ninety-five percent of the additional cost a school employee would be required to pay to enroll a spouse or state registered domestic partner in the public employees benefits board (PEBB) Uniform Medical Plan (UMP) Classic and the benefits have an actuarial value of at least ninety-five percent of the actuarial value of the PEBB UMP Classic's benefits.

(a) A subscriber who enrolled a spouse or state registered domestic partner under their SEBB medical may only attest during the following times:

(i) When a subscriber becomes eligible to enroll a spouse or state registered domestic partner in SEBB medical as described in WAC 182-31-150. The subscriber must complete the required form to enroll their spouse or state registered domestic partner, and include their attestation on that form. The school employee must submit the form to their SEBB organization. A subscriber on continuation coverage must submit the form to the SEBB program. If the subscriber's attestation results in a premium surcharge it will take effect the same date as SEBB medical begins.

(ii) During the annual open enrollment. A subscriber must attest if during the month prior to the annual open enrollment the subscriber was:

• Incurring the surcharge;

• Not incurring the surcharge because the spouse's or state registered domestic partner's share of the medical premium through their employer-based group medical was more than ninety-five percent of the additional cost a school employee would be required to pay to enroll a spouse or state registered domestic partner in the PEBB UMP Classic; or

• Not incurring the surcharge because the actuarial value of benefits provided through the spouse's or state registered domestic partner's employer-based group medical was less than ninety-five percent of the actuarial value of the PEBB UMP Classic's benefits.

A subscriber must update their attestation on the required form. A school employee must submit the form to their SEBB organization. A subscriber on continuation coverage must submit the form to the SEBB program. The subscriber's attestation or any correction to a subscriber's attestation must be received no later than December 31st of the year in which the annual open enrollment occurs. If the subscriber's attestation results in a premium surcharge, being added or removed, the change to the surcharge will take effect January 1st of the following year.

(iii) When there is a change in the spouse's or state registered domestic partner's employer-based group medical. A subscriber must update their attestation on the required form. A school employee must submit the form to their SEBB organization no later than sixty days after the spouse's or state registered domestic partner's employer-based group medical status changes. A subscriber on continuation coverage must submit the form to the SEBB program no later than sixty days after the spouse's or state registered domestic partner's employer-based group medical status changes.

• A change that results in a premium surcharge will begin the first day of the month following the status change. If that day is the first day of the month, the change to the premium surcharge begins on that day.

• A change that results in removing the premium surcharge will begin the first day of the month following receipt of the attestation. If that day is the first day of the month, the change to the premium surcharge begins on that day.

Exceptions:

(1) A school employee who waives SEBB medical as described in WAC 182-31-080 is not required to provide an attestation and no premium surcharge will be applied to their account as long as the employee remains in waived status.

(2) A school employee who covers their spouse or state registered domestic partner who has waived their own SEBB medical must attest as described in this subsection, but ((~~a~~)) will not incur a premium surcharge if the school employee provides an attestation that their spouse or state registered domestic partner is eligible for SEBB ((~~coverage~~)) medical.

(3) A subscriber who covers their spouse or state registered domestic partner who elected not to enroll in a TRICARE plan must attest as described in this subsection, but will not incur a premium surcharge if the subscriber provides an attestation that their spouse or state registered domestic partner is eligible for a TRICARE plan.

(b) A premium surcharge will be applied to a subscriber who does not attest as described in (a) of this subsection.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-30-070 The employer contribution is set by the health care authority (HCA) and paid to the HCA for all eligible school employees. School employees benefits board (SEBB) organizations must pay the employer contributions to the health care authority (HCA) for SEBB ((~~benefits~~)) insurance coverage for all eligible school employees and their enrolled dependents.

(1) Employer contributions are set by the HCA, and are subject to the approval of the governor for availability of funds as specifically appropriated by the legislature for that purpose. The employer contribution for school employees eligible under RCW 41.05.740 (6)(e) are set by the HCA.

(2) Employer contributions must include an amount determined by the HCA to pay administrative costs to administer SEBB benefits ((~~coverage~~)) for school employees.

(3) ((~~Eligible~~)) Each school employee of a SEBB organization on leave under the federal Family and Medical Leave Act (FMLA) or the paid family medical leave program is eligible for the employer contribution as described in WAC 182-31-110.

(4) The entire employer contribution is due and payable to HCA even if SEBB medical is waived as described in WAC 182-31-080, except for school employees eligible under WAC 182-30-130.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-30-075 Subscriber address requirements. (1) All school employees must provide their school employees benefits board (SEBB) organization with their correct address and update their address if it changes. A subscriber on continuation coverage must provide the SEBB program with their correct address and updates to their address if it changes.

(2) ((~~School employees who are appealing a decision to the school employees benefits board (SEBB) program~~)) In the event of an appeal, the appellant must update their address as required in WAC 182-32-055.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-30-080 When must a newly eligible school employee, or a school employee who regains eligibility for the employer contribution, elect school employees benefits board (SEBB) benefits and complete required forms? A school employee who is newly eligible or who regains eligibility for the employer contribution toward school employees benefits board (SEBB) benefits enrolls as described in this section.

(1) When a school employee is newly eligible for SEBB benefits:

(a) A school employee must complete the required forms indicating their enrollment elections, including an election to waive SEBB medical provided the school employee is eligible to waive SEBB medical and elects to waive as described in WAC 182-31-080. The required forms must be returned to the school employee's SEBB organization or contracted vendor. Their SEBB organization or contracted vendor must receive the forms no later than thirty-one days after the school employee becomes eligible for SEBB benefits under WAC 182-31-040.

(i) The school employee may enroll in supplemental life((~~, supplemental accidental death and dismemberment (AD&D),~~)) and supplemental long-term disability (LTD) insurance up to the guaranteed issue coverage amount without evidence of insurability if the required forms are returned to the school employee's SEBB organization or contracted vendor as required. ((~~The~~)) A school employee may apply for enrollment in supplemental life((~~, supplemental AD&D,~~)) and supplemental LTD insurance over the guaranteed issue coverage amount at any time during the calendar year by submitting the required form to the contracted vendor for approval. A school employee may enroll in supplemental accidental death and dismemberment (AD&D) insurance at anytime without evidence of insurability by submitting the required form to the contracted vendor.

(ii) If the school employee is eligible to participate in the salary reduction plan (see WAC 182-31-060), the school employee will automatically enroll in the premium payment plan upon enrollment in SEBB medical allowing medical premiums to be taken on a pretax basis. To opt out of the premium payment plan, a new school employee must complete the required form and return it to their SEBB organization. The form must be received by their SEBB organization no later than thirty-one days after the employee becomes eligible for SEBB benefits.

(iii) If a school employee is eligible to participate in the salary reduction plan (see WAC 182-31-060), the school employee may enroll in the state's medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP) or both, except as limited by subsection (4) of this section. To enroll in these ((~~supplemental~~)) SEBB benefits, the school employee must return the required form to their SEBB organization. The form must be received by the SEBB organization no later than thirty-one days after the school employee becomes eligible for SEBB benefits.

(b) If a newly eligible school employee's SEBB organization, or the authority's contracted vendor in the case of life insurance ((~~or accidental death and dismemberment (AD&D)~~)) and AD&D, does not receive the school employee's required forms indicating medical, dental, vision, life insurance, AD&D insurance, and LTD insurance elections, and the school employee's tobacco use status attestation within thirty-one days of the school employee becoming eligible, their enrollment will be as follows for those elections not received within thirty-one days:

(i) A medical plan ((~~as~~)) determined by the health care authority (HCA);

(ii) A dental plan ((~~as~~)) determined by the HCA;

(iii) A vision plan ((~~as~~)) determined by the HCA;

(iv) Basic life insurance;

(v) Basic AD&D insurance;

(vi) Basic LTD insurance;

(vii) Dependents will not be enrolled; and

(viii) A tobacco use premium surcharge will be incurred as described in WAC 182-30-050 (1)(b).

(2) The employer contribution toward SEBB benefits ((~~coverage~~)) ends according to WAC 182-31-050. When a school employee's employment ends, participation in the salary reduction plan ends.

(3) When a school employee regains eligibility for the employer contribution toward SEBB benefits ((~~coverage~~)), including following a period of leave (((~~,~~))) as described in WAC 182-31-100(1)(((~~,~~))) or 182-31-040(6), SEBB medical, dental, and vision begin the first day of the month following the school employee's return to work ((~~as~~)) if the SEBB organization anticipates the school employee is eligible for the employer contribution.

(a) ((~~The~~)) A school employee must complete the required forms indicating their enrollment elections, including an election to waive SEBB medical if the school employee chooses to waive SEBB medical as described in WAC 182-31-080. The required forms must be returned to the school employee's SEBB organization except as

described in (d) of this subsection. Forms must be received by the SEBB organization, life insurance contracted vendor, or AD&D contracted vendor, if required, no later than thirty-one days after the school employee regains eligibility except as described in (a)(i) and (b) of this subsection:

(i) A school employee who self-paid for supplemental ((~~SEBB~~)) life insurance ((~~coverage or SEBB AD&D insurance~~)) or supplemental AD&D coverage after losing eligibility will ((~~have~~)) maintain that level of coverage ((~~reinstated without evidence of insurability effective the first day of the month in which the school employee regains eligibility for the employer contribution toward SEBB benefits~~)) upon return;

(ii) A school employee who was eligible to continue supplemental life or supplemental AD&D insurance but discontinued that SEBB ((~~insurance~~)) supplemental coverage must submit evidence of insurability to the contracted vendor if they choose to reenroll when they regain eligibility for the employer contribution.

(b) A school employee does not have to return a form indicating supplemental LTD insurance elections. Their supplemental LTD insurance will be automatically reinstated effective the first day of the month they regain eligibility for the employer contribution toward SEBB benefits.

(c) If a school employee's SEBB organization, or contracted vendor accepting forms directly, does not receive the required forms within thirty-one days of the school ((~~employee's enrollment in SEBB, insurance coverage~~)) employee regaining eligibility, the school employee's enrollment for those elections not received will be as described in subsection (1)(b)(i) through (((~~(v) and (vii)~~))) (viii) of this section, except as described in (a)(i) and (b) of this subsection.

(d) If a school employee is eligible to participate in the salary reduction plan (see WAC 182-31-060), the school employee may enroll in the medical FSA or DCAP or both, except as limited by subsection (4) of this section. To enroll in these ((~~supplemental~~)) SEBB benefits, the school employee must return the required form to the contracted vendor ((~~of~~)) or their SEBB organization. The contracted vendor or school employee's SEBB organization must receive the form no later than thirty-one days after the school employee becomes eligible for SEBB benefits.

(4) If a school employee who is eligible to participate in the salary reduction plan (see WAC 182-31-060) is hired into a new position ((~~and~~)) that is anticipated to be eligible for SEBB benefits in the same year, the school employee may not resume participation in DCAP or medical FSA until the beginning of the next plan year, unless the time between employments is thirty days or less and within the current plan year. The school employee must notify the new SEBB organization of the transfer by providing the new SEBB organization the required form no later than thirty-one days after the school employee's first day of work with the new SEBB organization.

(5) A school employee will have uninterrupted coverage when moving from one SEBB organization to another within the same month or a consecutive month if they are eligible for the employer contribution towards SEBB benefits in the position they are leaving and are anticipated to be eligible for the employer contribution in the new position. SEBB ((~~insurance coverage~~)) benefits elections also remain the same when a school employee has a break in employment that does not interrupt their employer contribution toward SEBB ((~~insurance coverage~~)) benefits.

(6) A school employee returning to the same SEBB organization who is anticipated to work at least six hundred thirty hours in the coming school year, and who was receiving the employer contribution in August of the prior school year, will receive uninterrupted coverage from one school year to the next.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-30-085 What happens if my health plan becomes unavailable due to a change in contracted service area or eligibility for medicare? (1) A subscriber must select a new health plan ((~~during the school employees benefits board (SEBB) annual open enrollment period~~)) when their previously selected health plan becomes unavailable due to a change in contracting service area((~~. The required forms must be received no later than the last day of the annual open enrollment.~~)) as described below:

(a) When a health plan becomes unavailable during the plan year, a subscriber must elect a new health plan no later than sixty days after the date their previously selected health plan becomes unavailable.

(i) A school employee must submit the required form to their school employees benefits board (SEBB) organization electing their new health plan.

((~~(b) A subscriber on continuation coverage~~)) (ii) All other subscribers must submit the required forms to the SEBB program electing their new health plan.

(((~~(c)~~))) (iii) The effective date of the change in ((~~their~~)) health plan will be ((~~January 1st of the following year.~~

~~(2)~~))) the first day of the month following the later of the date the health plan becomes unavailable or the date the form is received. If that day is the first of the month, the change in health plans begins on that day.

(b) When a health plan becomes unavailable at the beginning of the next plan year, a subscriber must elect a new health plan no later than the last day of the SEBB annual open enrollment.

(i) A school employee must submit the required forms to their SEBB organization electing their new health plan.

(ii) Any other subscriber must submit the required forms to the SEBB program electing their new health plan.

(iii) The effective date of the change in health plan will be January 1st of the following year.

(c) A subscriber who fails to elect a new health plan within the required time period as required in ((~~subsection (1)~~)) (a) or (b) of this ((~~section~~)) subsection will be enrolled in a health plan designated by the director or their designee.

(((~~(3)~~))) (2) A subscriber must elect a new health plan when their previously selected health plan becomes unavailable due to the subscriber or subscriber's dependent ceasing to be eligible for their current health plan because of enrollment in medicare((~~.~~)) as described below:

(a) The required forms electing a new health plan must be received no later than sixty days after the date ((~~the~~)) their previously selected health plan becomes unavailable.

(((~~a~~))) (b) A school employee must submit the required forms to their ((~~employing agency~~)) SEBB organization electing their new health plan.

(((~~b) A subscriber on continuation coverage~~)) (c) All other subscribers must submit the required forms to the SEBB program electing their new health plan.

(((~~c~~))) (d) The effective date of the change in their health plan will be the first day of the month following the later of the date the health plan becomes unavailable or the date the form is received. If that day is the first of the month, the change in the health plan begins on that day.

(((~~4~~))) (e) A subscriber ((~~who fails to elect a new health plan within the required time period as required in subsection (3) of this section~~)) who is enrolled in a high deductible health plan (HDHP) with a health savings account (HSA), will not be eligible to receive contributions to the HSA, and will be liable for any tax penalties resulting from contributions made when they are no longer eligible.

(((~~5~~))) (3) A subscriber enrolled in a health plan as described in subsection ((~~(2) or (4)~~)) (1)(c) or (2)(e) of this section may not change health plans except as allowed in WAC 182-30-090.

AMENDATORY SECTION (Amending WSR 20-01-082, filed 12/12/19, effective 1/12/20)

WAC 182-30-090 When may a subscriber change health plans? A subscriber may change health plans at the following times:

(1) **During the annual open enrollment:** A subscriber may change health plans during the school employees benefits board (SEBB) annual open enrollment period. The subscriber must submit the required enrollment forms to change their health plan. A school employee submits the enrollment forms to their SEBB organization. A subscriber on continuation coverage submits the enrollment forms to the SEBB program. The required enrollment forms must be received no later than the last day of the annual open enrollment. Enrollment in the new health plan will begin January 1st of the following year.

(2) **During a special open enrollment:** A subscriber may revoke their health plan election and make a new election outside of the annual open enrollment if a special open enrollment event occurs. A special open enrollment event must be an event other than ((~~an~~)) a school employee gaining initial eligibility for SEBB benefits as described in WAC 182-31-040 or regaining eligibility for SEBB benefits as described in WAC 182-30-080. The change in enrollment must be allowable under Internal Revenue Code (IRC) and Treasury regulations, and correspond to and be consistent with the event that creates the special open enrollment for the subscriber, the subscriber's dependent, or both. To make a health plan change, ((~~the~~)) a subscriber must submit the required enrollment forms. The forms must be received no later than sixty days after the event occurs. A school employee submits the enrollment forms to their SEBB organization. A subscriber on continuation coverage submits the enrollment forms to the SEBB program. In addition to the required forms, a subscriber must provide evidence of the event that created the special open enrollment. New health plan coverage will begin the first day of the month following the later of the event date or the date the form is received. If that day is the first of the month, the change in enrollment begins on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, health plan coverage will begin the month in which the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption occurs. If the special open enrollment is due to the enrollment of an extended dependent or a dependent with a disability, the change in health plan coverage will begin the first day of the month following the later of the event date or the eligibility certification. Any one of the following events may create a special open enrollment:

(a) Subscriber acquires a new dependent due to:

(i) Marriage or registering a state registered domestic partnership;

(ii) Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or

(iii) A child becoming eligible as an extended dependent through legal custody or legal guardianship.

(b) Subscriber or a subscriber's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);

(c) Subscriber has a change in employment status that affects the subscriber's eligibility for the employer contribution toward their employer-based group health plan;

(d) Subscriber has a change in employment from a SEBB organization to a public school district that straddles county lines or is in a county that borders Idaho or Oregon, which results in the subscriber having different medical plans available. The subscriber may change their election if the change in employment causes:

(i) The subscriber's current medical plan to no longer be available, in this case the subscriber may select from any available medical plan; or

(ii) The subscriber has one or more new medical plans available, in this case the subscriber may select to enroll in a newly available plan.

(iii) As used in this subsection the term "public school district" shall be interpreted to not include charter schools and educational service districts.

(e) The subscriber's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan;

Note: As used in (((~~d~~))) (e) of this subsection ((~~special open enrollment~~)) "employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 26 C.F.R. 54.9801-6.

(f) Subscriber or a subscriber's dependent has a change in residence that affects health plan availability. If the subscriber moves and the subscriber's current health plan is not available in the new location the subscriber must select a new

health plan, otherwise there will be limited accessibility to network providers and covered services;

Exception: A dental plan is considered available if a provider is available within ((~~50~~)) fifty miles of the subscriber's new ((~~address~~)) residence.

(g) A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state registered domestic partner is not an eligible dependent);

(h) Subscriber or a subscriber's dependent ((~~becomes entitled to~~)) enrolls in coverage under medicaid or a state children's health insurance program (CHIP), or the subscriber or a subscriber's dependent loses eligibility for coverage under medicaid or CHIP;

(i) Subscriber or a subscriber's dependent becomes eligible for state premium assistance subsidy for SEBB health plan coverage from medicaid or CHIP;

(j) Subscriber or a subscriber's dependent ((~~becomes entitled to~~)) enrolls in coverage under medicare, or the subscriber or a subscriber's dependent loses eligibility for coverage under medicare. If the subscriber's current ((~~health~~)) medical plan becomes unavailable due to the subscriber's or a subscriber's dependent's ((~~entitlement to~~)) enrollment in medicare, the subscriber must select a new ((~~health~~)) medical plan as described in WAC 182-30-085(((~~1~~))) (2);

(k) Subscriber or a subscriber's dependent's current health plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA). The authority may require evidence that the subscriber or subscriber's dependent is no longer eligible for an HSA;

(l) Subscriber or a subscriber's dependent experiences a disruption of care for active and ongoing treatment that could function as a reduction in benefits for the subscriber or the subscriber's dependent. The subscriber may not change their health plan election if the subscriber's or dependent's physician stops participation with the subscriber's health plan unless the SEBB program determines that a continuity of care issue exists. The SEBB program will consider but not limit its consideration to the following:

(i) Active cancer treatment such as chemotherapy or radiation therapy;

(ii) Treatment following a recent organ transplant;

(iii) A scheduled surgery;

(iv) Recent major surgery still within the postoperative period; or

(v) Treatment for a high-risk pregnancy.

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

AMENDATORY SECTION (Amending WSR 20-01-082, filed 12/12/19, effective 1/12/20)

WAC 182-30-100 When may a school employee enroll, or revoke an election and make a new election under the premium payment plan, medical flexible spending arrangement (FSA), or dependent care assistance program (DCAP)? A school employee who is eligible to participate in the salary reduction plan as described in WAC 182-31-060 may enroll, or revoke their election and make a new election under the premium payment plan, medical flexible spending arrangement (FSA), or dependent care assistance program (DCAP) at the following times:

(1) When newly eligible under WAC 182-31-040 and enrolling as described in WAC 182-30-080(1).

(2) **During annual open enrollment:** An eligible school employee may elect to enroll in or opt out of participation under the premium payment plan during the annual open enrollment by submitting the required form to their school employees benefits board (SEBB) organization. An eligible school employee may elect to enroll or reenroll in the medical FSA, DCAP, or both during the annual open enrollment by submitting the required forms to their SEBB organization, the HCA or applicable contracted vendor as instructed. All required forms must be received no later than the last day of the annual open enrollment. The enrollment or new election becomes effective January 1st of the following year.

Note: School employees enrolled in a high deductible health plan (HDHP) with a health savings account (HSA) cannot also enroll in a medical FSA in the same plan year. School employees who elect both will only be enrolled in the HDHP with a HSA.

(3) **During a special open enrollment:** A school employee who is eligible to participate in the salary reduction plan may enroll or revoke their election and make a new election under the premium payment plan, medical FSA, or DCAP outside of the annual open enrollment if a special open enrollment event occurs. The enrollment or change in election must be allowable under Internal Revenue Code (IRC) and Treasury regulations, and correspond to and be consistent with the event that creates the special open enrollment. To make a change or enroll, the school employee must submit the required form to their SEBB organization. The SEBB organization must receive the required form and evidence of the event that created the special open enrollment no later than sixty days after the event occurs.

For purposes of this section, an eligible dependent includes any person who qualifies as a dependent of the school employee for tax purposes under IRC 26 U.S.C. Sec. 152 without regard to the income limitations of that section. It does not include a state registered domestic partner unless the state registered domestic partner otherwise qualifies as a dependent for tax purposes under IRC 26 U.S.C. Sec. 152.

(a) **Premium payment plan.** A school employee may enroll or revoke their election and elect to opt out of the premium payment plan when any of the following special open enrollment events occur, if the requested change corresponds to and is consistent with the event. The enrollment or election to opt out will be effective the first day of the month following the later of the event date or the date the required form is received. If that day is the first of the month, the enrollment or change in election begins on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, the enrollment or change in election will begin the first of the month in which the event occurs.

(i) School employee acquires a new dependent due to:

• Marriage;

• Registering a state registered domestic partnership when the dependent is a tax dependent of the school employee;

• Birth, adoption, or when the school employee has assumed a legal obligation for total or partial support in anticipation of adoption; or

• A child becoming eligible as an extended dependent through legal custody or legal guardianship.

(ii) School employee's dependent no longer meets SEBB eligibility criteria because:

• School employee has a change in marital status;

• School employee's domestic partnership with a state registered domestic partner who is a tax dependent is dissolved or terminated;

• An eligible dependent child turns age twenty-six or otherwise does not meet dependent child eligibility criteria;

• An eligible dependent ceases to be eligible as an extended dependent or as a dependent with a disability; or

• An eligible dependent dies.

(iii) School employee or a school employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by Health Insurance Portability and Accountability Act (HIPAA);

(iv) School employee has a change in employment status that affects the school employee's eligibility for their employer contribution toward their employer-based group health plan;

(v) The school employee's dependent has a change in their own employment status that affects their eligibility for the employer contribution toward their employer-based group health plan;

Exception: ((~~For the purposes of special open enrollment~~)) As used in (a)(v) of this subsection, "employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 26 C.F.R. 54.9801-6.

(vi) School employee or a school employee's dependent has a change in enrollment under an employer-based group health plan during its annual open enrollment that does not align with the SEBB annual open enrollment;

(vii) School employee or a school employee's dependent has a change in residence that affects health plan availability;

(viii) School employee's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States, and that change in residence resulted in the dependent losing their health insurance;

(ix) A court order requires the school employee or any other individual to provide insurance coverage for an eligible dependent of the school employee (a former spouse or former state registered domestic partner is not an eligible dependent);

(x) School employee or a school employee's dependent ((~~becomes entitled to~~)) enrolls in coverage under medicaid or a state children's health insurance program (CHIP), or the school employee or a school employee's dependent loses eligibility for coverage under medicaid or CHIP;

(xi) School employee or a school employee's dependent becomes eligible for state premium assistance subsidy for SEBB health plan coverage from medicaid or CHIP;

(xii) School employee or a school employee's dependent ((~~becomes entitled to~~)) enrolls in coverage under medicare or the school employee or a school employee's dependent loses eligibility for coverage under medicare;

(xiii) School employee or a school employee's dependent's current ((~~health~~)) medical plan becomes unavailable because the school employee or enrolled dependent is no longer eligible for a HSA. The HCA may require evidence that the school employee or a school employee's dependent is no longer eligible for a HSA;

(xiv) School employee or a school employee's dependent experiences a disruption of care for active and ongoing treatment, that could function as a reduction in benefits for the school employee or a school employee's dependent. The school employee may not change their health plan election if the school employee's or dependent's physician stops participation with the school employee's health plan unless the SEBB program determines that a continuity of care issue exists. The SEBB program will consider but not limit its consideration to the following:

• Active cancer treatment such as chemotherapy or radiation therapy;

• Treatment following a recent organ transplant;

• A scheduled surgery;

• Recent major surgery still within the postoperative period; or

• Treatment for a high-risk pregnancy.

(xv) School employee or school employee's dependent becomes eligible and enrolls in a TRICARE plan, or loses eligibility for a TRICARE plan.

(xvi) Subscriber has a change in employment from a SEBB organization to a public school district that straddles county lines or is in a county that borders Idaho or Oregon, which results in the subscriber having different medical plans available, and the subscriber changes their election. The subscriber may change their election if the change in employment causes:

• The subscriber's current medical plan to no longer be available, in this case the subscriber may select from any available medical plan; or

• The subscriber has one or more new medical plans available, in this case the subscriber may select to enroll in a newly available plan.

• As used in this subsection the term "public school district" shall be interpreted to not include charter schools and educational service districts.

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

(b) **Medical FSA.** A school employee may enroll or revoke their election and make a new election under the medical FSA when any one of the following special open enrollment events occur, if the requested change corresponds to and is consistent with the event. The enrollment or new election will be effective the first day of the month following the

later of the event date or the date the required form and evidence of the event that created the special open enrollment is received by the SEBB organization. If that day is the first of the month, the enrollment or change in election begins on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, the enrollment or change in election will begin the first of the month in which the event occurs.

(i) School employee acquires a new dependent due to:

• Marriage;

• Registering a state registered domestic partnership when the dependent is a tax dependent of the school employee;

• Birth, adoption, or when the school employee has assumed a legal obligation for total or partial support in anticipation of adoption; or

• A child becoming eligible as an extended dependent through legal custody or legal guardianship.

(ii) School employee's dependent no longer meets SEBB eligibility criteria because:

• School employee has a change in marital status;

• School employee's domestic partnership with a state registered domestic partner who qualifies as a tax dependent is dissolved or terminated;

• An eligible dependent child turns age twenty-six or otherwise does not meet dependent child eligibility criteria;

• An eligible dependent ceases to be eligible as an extended dependent or as a dependent with a disability; or

• An eligible dependent dies.

(iii) School employee or a school employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by HIPAA;

(iv) School employee or a school employee's dependent has a change in employment status that affects the school employee's or a dependent's eligibility for the medical FSA;

(v) A court order requires the school employee or any other individual to provide insurance coverage for an eligible dependent of the school employee (a former spouse or former state registered domestic partner is not an eligible dependent);

(vi) School employee or a school employee's dependent ((~~becomes entitled to~~)) enrolls in coverage under medicaid or CHIP, or the school employee or a school employee's dependent loses eligibility for coverage under medicaid or CHIP;

(vii) School employee or a school employee's dependent ((~~becomes entitled to~~)) enrolls in coverage under medicare.

(c) **DCAP.** A school employee may enroll or revoke their election and make a new election under the DCAP when any one of the following special open enrollment events occur, if the requested change corresponds to and is consistent with the event. The enrollment or new election will be effective the first day of the month following the later of the event date or the date the required form and evidence of the event that created the special open enrollment is received by the SEBB organization. If that day is the first of the month, the enrollment or change in election begins on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, the enrollment or change in election will begin the first of the month in which the event occurs.

(i) School employee acquires a new dependent due to:

• Marriage;

• Registering a state registered domestic partnership if the state registered domestic partner qualifies as a tax dependent of the school employee;

• Birth, adoption, or when the school employee has assumed a legal obligation for total or partial support in anticipation of adoption; or

• A child becoming eligible as an extended dependent through legal custody or legal guardianship.

(ii) School employee or a school employee's dependent has a change in employment status that affects the school employee's or a dependent's eligibility for DCAP;

(iii) School employee or school employee's dependent has a change in enrollment under an employer-based group health plan during its annual open enrollment that does not align with the SEBB annual open enrollment;

(iv) School employee changes dependent care provider; the change to the DCAP election amount can reflect the cost of the new provider;

(v) School employee or school employee's spouse experiences a change in the number of qualifying individuals as defined in IRC 26 U.S.C. Sec. 21 (b)(1);

(vi) School employee's dependent care provider imposes a change in the cost of dependent care; school employee may make a change in the DCAP election amount to reflect the new cost if the dependent care provider is not a qualifying relative of the school employee as defined in IRC 26 U.S.C. Sec. 152.

NEW SECTION

WAC 182-30-140 What is the process for school districts to offer optional benefits? (1) School districts may offer optional benefits that do not compete with any form of the basic or optional benefits offered in the school employees' benefits board (SEBB) program either under the SEBB's authority in RCW 41.05.740 or offered under the health care authority's (HCA) authority in the salary reduction plan authorized in RCW 41.05.300 and 41.05.310. Optional benefits may include:

(a) Emergency transportation;

(b) Identity protection;

(c) Legal aid;

(d) Long-term care insurance;

(e) Noncommercial personal automobile insurance;

(f) Personal homeowner's or renter's insurance;

(g) Pet insurance;

(h) Specified disease or illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance offered as an independent, noncoordinated benefit regulated by the office of the insurance commissioner;

(i) Travel insurance; and

(j) Voluntary employees' beneficiary association accounts.

(2) Any school districts providing optional benefits must:

(a) Report optional benefits on the form designed and communicated by the HCA; and

(b) Submit the form so it is received by December 1st of each year for the following calendar year as required in RCW 28A.400.280 (2)(b).

(3) The HCA, in consultation with the SEBB will review the optional benefits offered by school districts as described in section 3, chapter 231, Laws of 2020 (HB 2458).

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 182-30-081	School employees benefits board (SEBB) first annual open enrollment.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-31-020 Definitions. The following definitions apply throughout this chapter unless the context clearly indicates another meaning:

"Accidental death and dismemberment insurance" or "AD&D" means basic accidental death and dismemberment (AD&D) insurance paid for by the SEBB organization, as well as supplemental accidental death and dismemberment insurance offered to and paid for by school employees for themselves and their dependents.

"Annual open enrollment" means an annual event set aside for a period of time by the HCA when subscribers may make changes to their health plan enrollment and salary reduction elections for the following plan year. During the annual open enrollment, subscribers may transfer from one health plan to another, enroll or remove dependents from coverage, ((~~or~~)) enroll in coverage, or waive enrollment in SEBB medical. School employees eligible to participate in the salary reduction plan may enroll in or change their election under the dependent care assistance program (DCAP), or the medical flexible spending arrangement (FSA). They may also enroll in or opt out of the premium payment plan.

"Authority" or "HCA" means the Washington state health care authority.

"Board" means the school employees benefits board established under provisions of RCW 41.05.740.

"Calendar days" or "days" means all days including Saturdays, Sundays, and all state legal holidays as set forth in RCW 1.16.050.

"Consolidated Omnibus Budget Reconciliation Act" or "COBRA" means continuation coverage as administered under 42 U.S.C. Secs. 300bb-1 through 300bb-8.

"Continuation coverage" means the temporary continuation of ((~~health plan coverage~~)) SEBB benefits available to enrollees under the Consolidated Omnibus Budget Reconciliation Act (COBRA), 42 U.S.C. Secs. 300bb-1 through 300bb-8, the Uniformed Services Employment and Reempl oyment Rights Act (USERRA), 38 U.S.C. Secs. 4301 through 4335, or SEBB policies.

"Contracted vendor" means any person, persons, or entity under contract or agreement with the HCA to provide goods or services for the provision or administration of SEBB benefits. The term "contracted vendor" includes subcontractors of the HCA and subcontractors of any person, persons, or entity under contract or agreement with the HCA that provide goods or services for the provision or administration of SEBB benefits.

"Dependent" means a person who meets eligibility requirements in WAC 182-31-140.

"Dependent care assistance program" or "DCAP" means a benefit plan whereby school employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan under chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 129 or other sections of the Internal Revenue Code.

"Director" means the director of the authority.

"Documents" means papers, letters, writings, electronic mail, electronic files, or other printed or written items.

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

"Employer-based group health plan" means group medical, group vision, and group dental related to a current employment relationship. It does not include medical, vision, or dental coverage available to retired employees, individual market medical or dental coverage, or government-sponsored programs such as medicare or medicaid.

"Employer-based group medical" means group medical related to a current employment relationship. It does not include medical coverage available to retired employees, individual market medical coverage, or government-sponsored programs such as medicare or medicaid.

"Employer contribution" means the funding amount paid to the HCA by a school employees benefits board (SEBB) organization for its eligible school employees as described under WAC 182-30-130 and 182-31-040.

"Enrollee" means a person who meets all eligibility requirements defined in chapter 182-31 WAC or WAC 182-30-130, who is enrolled in school employees benefits board (SEBB) benefits, and for whom applicable premium payments have been made.

"Forms" or "form" means both paper forms and forms completed electronically.

"Health plan" means a plan offering medical, vision, dental, or any combination of these coverages, developed by the ((~~SEBB~~)) board and provided by a contracted vendor or self-insured plans administered by the HCA.

"Layoff," for purposes of this chapter, means a change in employment status due to a SEBB ((~~organization~~)) organization's lack of funds or a SEBB organization's organizational change.

"Life insurance" means basic life insurance paid for by the SEBB organization, as well as supplemental life insurance offered to and paid for by school employees for themselves and their dependents.

"Long-term disability insurance" or "LTD insurance" ((~~or "long-term disability insurance"~~)) means any basic long-term disability insurance paid for by the SEBB organization and supplemental long-term disability insurance offered to and paid for by the school employee.

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby eligible school employees may reduce their salary before taxes to pay for medical

expenses not reimbursed by insurance as provided in the salary reduction plan established under chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"PEBB" means the public employees benefits board.

"Plan year" means the time period established by the authority.

"Premium payment plan" means a benefit plan whereby school employees may pay their share of group health plan premiums with pretax dollars as provided in the salary reduction plan under chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"Premium surcharge" means a payment required from a subscriber, in addition to the subscriber's medical premium contribution, due to an enrollee's tobacco use or an enrolled subscriber's spouse or state registered domestic partner choosing not to enroll in their employer-based group medical when:

• The spouse's or state registered domestic partner's share of the medical premium is less than ninety-five percent of the additional cost an employee would be required to pay to enroll a spouse or state registered domestic partner in the public employees benefits board (PEBB) Uniform Medical Plan (UMP) Classic; and

• The benefits have an actuarial value of at least ninety-five percent of the actuarial value of PEBB UMP Classic benefits.

((~~"Public employees benefits board" or "PEBB" means the board established under RCW 41.05.055.~~))

"Salary reduction plan" means a benefit plan whereby school employees may agree to a reduction of salary on a pretax basis to participate in the dependent care assistance program, medical flexible spending arrangement, or premium payment plan offered pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"School employee" means:

• All employees of school districts and charter schools established under chapter 28A.710 RCW;

• Represented employees of educational service districts; and

• Effective January 1, 2024, all employees of educational service districts.

"School employees benefits board organization" or "SEBB organization" means a public school district or educational service district or charter school established under chapter 28A.710 RCW that is required to participate in benefit plans provided by the school employees benefits board.

"School year" means school year as defined in RCW 28A.150.203(11).

"SEBB" means the school employees benefits board ((~~established in RCW 41.05.740~~)).

"SEBB benefits" means one or more insurance coverages or other school employee benefits administered by the SEBB program within the HCA.

"SEBB insurance coverage" means any health plan, life insurance, accidental death and dismemberment insurance, or long-term disability insurance administered as a SEBB benefit.

"SEBB program" means the program within the HCA that administers insurance and other benefits for eligible school employees (as described in WAC 182-31-040 or 182-30-130) and eligible dependents (as described in WAC 182-31-140).

"Special open enrollment" means a period of time when subscribers may make changes to their health plan enrollment and salary reduction elections outside of the annual open enrollment period when specific life events occur. During the special open enrollment subscribers may change health plans and enroll or remove dependents from coverage. Additionally, school employees may enroll in or waive enrollment in SEBB medical. School employees eligible to participate in the salary reductions plan may enroll in or revoke their election under the DCAP, medical FSA, or the premium payment plan and make a new election. For special open enrollment events related to specific SEBB benefits, see WAC 182-30-090, 182-30-100, 182-31-080, and 182-31-150.

"State registered domestic partner" has the same meaning as defined in RCW 26.60.020(1) and substantially equivalent legal unions from other jurisdictions as defined in RCW 26.60.090.

"Subscriber" means the school employee or continuation coverage enrollee who has been determined eligible by the SEBB program or SEBB organizations, is enrolled in SEBB benefits, and is the individual to whom the SEBB program and contracted vendors will issue all notices, information, requests, and premium bills on behalf of an enrollee.

"Supplemental coverage" means any life insurance, accidental death and dismemberment (AD&D) insurance coverage, or long-term disability coverage purchased by the school employee in addition to the coverage provided by the school employees benefits board (SEBB) organization.

"Tobacco products" means any product made with or derived from tobacco that is intended for human consumption, including any component, part, or accessory of a tobacco product. This includes, but is not limited to, cigars, cigarettes, pipe tobacco, chewing tobacco, snuff, and other tobacco products. It does not include e-cigarettes or United States Food and Drug Administration (FDA) approved quit aids.

"Tobacco use" means any use of tobacco products within the past two months. Tobacco use, however, does not include the religious or ceremonial use of tobacco.

"Waive" means an eligible school employee affirmatively declining enrollment in ((~~a SEBB health plan~~)) SEBB medical because the school employee is enrolled in other employer-based group medical, a TRICARE plan((~~s~~)), or medicare as allowed under WAC 182-31-080.

"Week" means a seven-day period starting on Sunday and ending on Saturday.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-31-030 What are the obligations of a school employees benefits board (SEBB) organization in the application of school employee eligibility? (1) All school employees benefits board (SEBB) organizations must carry out all actions, policies, and guidance issued by the SEBB program which are necessary for the operation of benefit plans, education of school employees, claims administra-

tion, and appeals process including those described in chapters 182-30, 182-31, and 182-32 WAC. SEBB organizations must:

(a) Use the methods provided by the SEBB program to determine eligibility and enrollment in benefits;

(b) Provide eligibility determination reports with content and in a format designed and communicated by the SEBB program;

(c) Support SEBB program auditing of eligibility and enrollment decisions as needed; and

(d) Carry out corrective action and pay any penalties imposed by the health care authority (HCA) and established by the ((~~SEBB~~)) board when the SEBB organization's eligibility determinations fail to comply with the criteria under these rules.

(2) SEBB organizations must determine school employee eligibility for SEBB benefits and the employer contribution according to the criteria in WAC 182-31-040 and 182-31-050. SEBB organizations must:

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

(b) Inform a school employee in writing whether or not they are eligible for SEBB benefits upon employment. The written ((~~communication~~)) notice must include information about the school employee's right to appeal eligibility and enrollment decisions. A school employee eligible for SEBB benefits must have no less than ten calendar days after the date of notice to elect coverage;

(c) Routinely monitor all school employees work hours to establish eligibility and maintain the employer contribution toward SEBB benefits ((~~coverage~~));

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

(e) Inform a school employee in writing whether or not they are eligible for SEBB benefits and the employer contribution whenever there is a change in work pattern((~~s~~)) such that the school employee's eligibility status changes. Whenever this occurs, SEBB organizations must inform the school employee of the right to appeal eligibility and enrollment decisions. A school employee eligible for SEBB benefits must have no less than ten calendar days after the date of notice to elect coverage.

(3) SEBB organizations must determine school employee's dependents eligibility for SEBB benefits according to the criteria in WAC 182-31-140.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-31-050 When does eligibility for the employer contribution for school employees benefits board (SEBB) benefits end? (1) The employer contribution toward school employees benefits board (SEBB) benefits ends the last day of the month in which the school year ends. The employer contribution toward SEBB benefits will end earlier than the end of the school year if one of the following occurs:

(a) The SEBB organization terminates the employment relationship. In this case, eligibility for the employer contribution ends the last day of the month in which the employer-initiated termination notice is effective;

(b) The school employee terminates the employment relationship. In this case, eligibility for the employer contribution ends the last day of the month in which the school employee's resignation is effective; or

(c) The school employee's work pattern is revised such that the school employee is no longer anticipated to work six hundred thirty hours during the school year. In this case, eligibility for the employer contribution ends as of the last day of the month in which the change is effective.

(2) If the SEBB organization deducted the school employee's portion of the premium for SEBB ((~~benefits~~)) insurance coverage from their pay after the school employee was no longer eligible for the employer contribution, SEBB benefits end the last day of the month for which school employee premiums were deducted to prevent a rescission of SEBB benefits. The SEBB organization must refund any premiums deducted for the school employee's portion of the premium that were deducted in advance of any month's coverage for which the school employee is no longer eligible for the employer contribution.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-31-070 Is dual enrollment in school employees benefits board (SEBB) prohibited? School employees benefits board (SEBB) ((~~health plan~~)) medical, dental, and vision coverage is limited to a single enrollment per individual.

(1) An individual who has more than one source of eligibility for enrollment in SEBB ((~~health plan~~)) medical, dental, and vision coverage (called "dual eligibility") is limited to one enrollment.

(2) An eligible school employee may waive SEBB medical and enroll as a dependent under the ((~~health~~)) medical plan of their spouse, state registered domestic partner, or parent as described in WAC 182-31-080.

(3) A dependent enrolled in ((~~a SEBB health plan~~)) SEBB medical, dental, or vision who becomes eligible for SEBB benefits as a school employee must elect to enroll in SEBB benefits as described in WAC 182-30-080(1). This includes making an election to enroll in or waive enrollment in SEBB medical as described in WAC 182-31-080 (1)(a).

(a) If the school employee does not waive enrollment in SEBB medical, the school employee is not eligible to remain enrolled in their spouse's, state registered domestic partner's, or parent's SEBB medical as a dependent. If the school employee's spouse, state registered domestic partner, or parent does not remove the school employee (who is enrolled as a dependent) from their subscriber account, the SEBB program will terminate the school employee's enrollment as a dependent the last day of the month before the school employee's enrollment in SEBB benefits begins as described in WAC 182-31-040.

Exception: An enrolled dependent who becomes newly eligible, at the start of the school year, for SEBB benefits as a school employee could be dual-enrolled in SEBB ((~~coverage~~)) medical, dental, and vision for one month. This exception is only allowed for the first month the dependent is enrolled as a school employee.

(b) If the school employee elects to waive their enrollment in SEBB medical, the school employee will remain enrolled in SEBB medical under their spouse's, state registered domestic partner's, or parent's SEBB ((~~health plan~~)) medical as a dependent.

(4) A child who is eligible for medical, dental, and vision under two subscribers may be enrolled ((~~as a dependent under the health plan of only one~~)) under both subscribers but is limited to a single enrollment in SEBB medical, a single enrollment in SEBB dental, and a single enrollment in SEBB vision.

(5) When a school employee is eligible for the employer contribution toward((~~s~~)) SEBB benefits due to employment in more than one SEBB organization the following provisions apply:

(a) When a school employee is eligible for the employer contribution during a school year under WAC 182-31-040 and 182-30-130 the SEBB organization that has determined the school employee eligible under WAC 182-31-040 must make the employer contribution;

(b) If the school employee is eligible for the employer contribution under WAC 182-31-040 at two different SEBB organizations, the school employee must choose to enroll under only one SEBB organization;

(c) If the school employee is eligible for the employer contribution under WAC 182-30-130 at two different SEBB organizations, the school employee must choose to enroll under only one SEBB organization;

(d) If the school employee loses eligibility under one SEBB organization, they ((~~may choose to enroll in the other SEBB organization they were eligible for the employer contribution at. The school employee~~)) must notify their other SEBB organization ((~~they were eligible for the employer contribution at~~)) no later than sixty days from the date of loss of the first SEBB ((~~coverage~~)) benefits in order to transfer coverage;

(e) The school employee's elections remain the same when a school employee transfers their enrollment under one SEBB organization to another SEBB organization without a break in SEBB benefits for one month or more, as described in (d) of this subsection.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-31-080 When may a school employee waive enrollment in school employees benefits board (SEBB) medical and when may they enroll in SEBB medical after having waived enrollment? A school employee may waive enrollment in school employees benefits board (SEBB) medical if they are enrolled in other employer-based group medical, a TRICARE plan, or medicare as described in subsection (1)(a) through (c) of this section. A special open enrollment event must be an event other than a school employee gaining initial eligibility for SEBB benefits. A school employee who waives enrollment in SEBB medical must enroll in dental, vision, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, and basic long-term disability insurance.

(1) To waive enrollment in SEBB medical, the school employee must submit the required form to their SEBB organization at one of the following times:

(a) **When the school employee becomes eligible:** A school employee may waive SEBB medical when they become eligible for SEBB benefits. The school employee must indicate their election to waive enrollment in SEBB medical on the required form and submit the form to their SEBB organization. The SEBB organization must receive the form no later than thirty-one days after the date the school employee becomes eligible for SEBB benefits (see WAC 182-30-080). SEBB medical will be waived as of the date the school employee becomes eligible for SEBB benefits.

(b) **During the annual open enrollment:** A school employee may waive SEBB medical during the annual open enrollment. The required form must be received by the school employee's SEBB organization before the end of the annual open enrollment. SEBB medical will be waived beginning January 1st of the following year.

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

The school employee must submit the required form to their SEBB organization. The SEBB organization must receive the form no later than sixty days after the event that creates the special open enrollment. In addition to the required form, the school employee must provide evidence of the event that creates the special open enrollment to their SEBB organization.

SEBB medical will be waived the last day of the month following the later of the event date or the date the required form is received. If that day is the first of the month, SEBB medical will be waived the last day of the previous month. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, SEBB medical will be waived the last day of the previous month.

(2) If a school employee waives SEBB medical, the school employee may not enroll dependents in SEBB medical.

(3) Once SEBB medical is waived, the school employee is only allowed to enroll in SEBB medical at the following times:

(a) During the annual open enrollment. The required form must be received by the school employee's SEBB organization before the end of the annual open enrollment. SEBB medical will begin January 1st of the following year.

(b) During a special open enrollment. A special open enrollment allows a school employee to revoke their election and make a new election outside of the annual open enrollment. A special open enrollment may be created when one of the events described in subsection (4) of this section occurs.

The school employee must submit the required form to their SEBB organization. The SEBB organization must receive the form no later than sixty days after the event that

creates the special open enrollment. In addition to the required form, the school employee must provide evidence of the event that creates the special open enrollment to the SEBB organization.

SEBB medical will begin the first day of the month following the later of the event date or the date the required form is received. If that day is the first of the month, coverage is effective on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, SEBB medical for the school employee will begin ((~~for a school employee~~)) on the first day of the month in which the event occurs (((~~see WAC 182-31-150(3)) for the~~)). SEBB medical ((~~effective date of a~~)) for the newly born child, newly adopted child, spouse, or state-registered domestic partner((~~,~~)) will begin as described in WAC 182-31-150 (3)(a)(iv).

(4) **Special open enrollment:** Any one of the events in (a) through (k) of this subsection may create a special open enrollment. The change in enrollment must be allowable under the Internal Revenue Code (IRC) and Treasury regulations, and correspond to and be consistent with the event that creates the special open enrollment for the school employee, the school employee's dependent, or both.

(a) School employee acquires a new dependent due to:

(i) Marriage or registering ((~~for~~)) a state registered domestic partnership;

(ii) Birth, adoption, or when the school employee has assumed a legal obligation for total or partial support in anticipation of adoption; or

(iii) A child becoming eligible as an extended dependent through legal custody or legal guardianship.

(b) School employee or a school employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);

(c) School employee has a change in employment status that affects the school employee's eligibility for their employer contribution toward their employer-based group medical;

(d) The school employee's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group medical;

Note: As used in (d) of this subsection "employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 26 C.F.R. 54.9801-6.

(e) School employee or a school employee's dependent has a change in enrollment under an employer-based group medical plan during its annual open enrollment that does not align with the SEBB program's annual open enrollment;

(f) School employee's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States and that change in residence results in the dependent losing their health insurance;

(g) A court order requires the school employee or any other individual to provide a health plan for an eligible dependent of the school employee (a former spouse or former state registered domestic partner is not an eligible dependent);

(h) School employee or a school employee's dependent ((~~becomes entitled to~~)) enrolls in coverage under medicaid or a state children's health insurance program (CHIP), or the school employee or a school employee's dependent loses eligibility for coverage under medicaid or CHIP;

Note: A school employee may only return from having waived SEBB medical for the events described in (h) of this subsection. A school employee may not waive their SEBB medical for the events described in (h) of this subsection.

(i) School employee or a school employee's dependent becomes eligible for state premium assistance subsidy for SEBB health plan coverage from medicaid or ((~~a state children's health insurance program (CHIP)~~)) CHIP;

(j) School employee or a school employee's dependent becomes eligible and enrolls in a TRICARE plan, or loses eligibility for a TRICARE plan;

(k) School employee becomes eligible and enrolls in medicare, or loses eligibility for medicare.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-31-090 When is an enrollee eligible to continue school employees benefits board (SEBB) benefits under Consolidated Omnibus Budget Reconciliation Act (COBRA)? (1) A school employee or a school employee's dependent who loses eligibility for the employer contribution toward school employees benefits board (SEBB) benefits and who qualifies for continuation coverage under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) may continue coverage for all or any combination of SEBB medical, dental, or vision.

(2) A school employee or a school employee's dependent may continue SEBB ((~~health plan coverage~~)) medical, dental, or vision under COBRA by self-paying the premium and applicable premium surcharges set by the health care authority (HCA):

((~~**Note:** Based on RCW 26.60.015 and SEBB policy resolution SEBB 2018-01 a subscriber's state registered domestic partner and the state registered domestic partner's children may continue SEBB benefits on the same terms and conditions as a legal spouse or child under COBRA.~~))

(a) The election must be received by the SEBB program no later than sixty days from the date the school employee's or school employee's dependent's SEBB health plan coverage ended or from the postmark date on the election notice sent by the SEBB program, whichever is later;

(b) The first premium payment under COBRA coverage and applicable premium surcharges are due to the HCA no later than forty-five days after the election period ends as described in (a) of this subsection. Following the enrollee's first premium payment, premiums and applicable premium surcharges must be paid as described in WAC 182-30-040 (1)(c);

(c) COBRA continuation coverage enrollees who voluntarily terminate their COBRA coverage will not be eligible to reenroll in COBRA coverage unless they regain eligibility as described in WAC 182-31-040. Those who request to termi-

nate their COBRA coverage must do so in writing. COBRA coverage will end on the last day of the month in which the SEBB program receives the termination request or on the last day of the month specified in the COBRA enrollee's termination request, whichever is later. If the termination request is received on the first day of the month, COBRA coverage will end on the last day of the previous month;

(d) A school employee enrolled in a medical flexible spending arrangement (FSA) and the school employee's dependents will have an opportunity to continue making contributions to their medical FSA by electing COBRA if on the date of the qualifying event, as described under 42 U.S.C. Sec. 300bb-3, the school employee's medical FSA has a greater amount in remaining benefits than remaining contribution payments for the current year. The election must be received by the contracted vendor no later than sixty days from the date the SEBB health plan coverage ended or from the postmark date on the election notice sent by the contracted vendor, whichever is later. The first premium payment under COBRA coverage is due to the contracted vendor no later than forty-five days after the election period ends as described above.

(3) A subscriber's state registered domestic partner and the state registered domestic partner's children may continue SEBB medical, dental, or vision on the same terms and conditions as spouses and other eligible dependents under COBRA as described under RCW 26.60.015.

(4) Medical, dental, and vision coverage under COBRA begin on the first day of the month following the day the COBRA enrollee loses eligibility for the employer contribution as described in WAC 182-31-050.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-31-100 What options for continuation coverage are available to school employees and their dependents during certain types of leave or when employment ends due to a layoff? School employees who have established eligibility for school employees benefits board (SEBB) benefits as described in WAC 182-31-040 may continue coverage for themselves and their dependents during certain types of leave or when their employment ends due to a layoff.

(1) School employees who are no longer eligible for the employer contribution toward SEBB benefits due to an event described in (b)(i) through (v) of this subsection may continue ((~~SEBB benefits~~)) coverage by self-paying the premium and applicable premium surcharges set by the health care authority (HCA) from the date eligibility for the employer contribution is lost:

(a) School employees may continue any combination of medical, dental, or vision, and may also continue life insurance((~~,~~)) and accidental death and dismemberment (AD&D) insurance. If life insurance or AD&D insurance is elected, both basic life and basic AD&D insurance must be continued. School employees who continue basic life insurance and basic AD&D insurance may also continue supplemental life and AD&D insurance;

(b) School employees in the following circumstances who lose their eligibility for the employer contribution toward SEBB benefits qualify to continue coverage under this subsection:

(i) School employees who are on authorized leave without pay;

(ii) School employees who are receiving time-loss benefits under workers' compensation;

(iii) School employees who are called to active duty in the uniformed services as defined under USERRA;

(iv) School employees whose employment ends due to a layoff as defined in WAC 182-31-020; and

(v) School employees who are applying for disability retirement.

(c) The school employee's elections must be received by the SEBB program no later than sixty days from the date the school employee's SEBB health plan coverage ended or from the postmark date on the election notice sent by the SEBB program, whichever is later;

(d) School employees may self-pay for a maximum of twenty-nine months. The school employee's first premium payment and applicable premium surcharges are due no later than forty-five days after the election period ends as described in (c) of this subsection.

Premiums and applicable premium surcharges associated with continuing SEBB medical, must be made to the HCA as well as premiums associated with continuing SEBB dental and vision insurance coverage. Premiums associated with continuing life insurance coverage or AD&D insurance coverage must be made to the contracted vendor. Following the school employee's first premium payment, the school employee must pay the premium amounts for SEBB ((~~benefits~~)) insurance coverage and applicable premium surcharges as premiums become due; and

(e) If the school employee's monthly premium or applicable premium surcharges remain unpaid for sixty days from the original due date, the school employee's SEBB ((~~benefits~~)) insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharges were paid as described in WAC 182-30-040 (1)((~~(b)~~)) (c).

(2) The number of months that school employees self-pay the premium while eligible as described in subsection (1) of this section will count toward the total months of continuation coverage allowed under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). School employees who are no longer eligible for continuation coverage as described in subsection (1) of this section but who have not used the maximum number of months allowed under COBRA coverage may continue medical, dental, vision, or any combination of them for the remaining difference in months by self-paying the premium and applicable premium surcharges as described in WAC 182-31-090.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-31-110 What options are available if a school employee is approved for the federal Family and Medical Leave Act (FMLA) or the paid family and medical leave program? (1) A school employee on approved leave under the federal Family and Medical Leave Act

(FMLA) ((~~or the family and medical leave insurance program under chapter 50A.04 RCW (paid family and medical leave program)~~)) may continue to receive the employer contribution toward school employees benefits board (SEBB) ((~~insurance coverage~~)) benefits in accordance with the federal FMLA ((~~or RCW 50A.04.245~~)). The school employee may also continue current supplemental life, supplemental accidental death and dismemberment (AD&D), and supplemental long-term disability (LTD) insurance. The school employee's SEBB organization is responsible for determining if the school employee is eligible for leave under FMLA and the duration of such leave. ((~~The employment security department is responsible for determining if the school employee is eligible for leave under the paid family and medical leave program.~~

~~(2) If a school employee's monthly premium or applicable premium surcharges remain unpaid for sixty days from the original due date, the school employee's SEBB benefits will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharges were paid.~~))

(2) A school employee on approved leave under the paid family and medical leave program under chapter 50A.05 RCW may continue to receive the employer contribution toward SEBB benefits in accordance with RCW 50A.35.020. The school employee may also continue current supplemental life, supplemental AD&D, and supplemental LTD insurance. The employment security department is responsible for determining if the school employee is eligible for the paid family and medical leave program.

(3) If a school employee exhausts the period of leave approved under FMLA or paid family and medical leave, SEBB benefits may be continued by self-paying the premium and applicable premium surcharges set by the health care authority (HCA), with no contribution from the SEBB organization, as described in WAC 182-31-100(1).

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-31-120 What options for continuation coverage are available to school employees during their appeal of a grievance? (1) A school employee awaiting the hearing outcome of a grievance action before any of the following may continue their school employees benefits board (SEBB) insurance coverage by self-paying the premium and applicable premium surcharges set by the health care authority (HCA), with no contribution from the SEBB organization, on the same terms as a school employee who is granted leave as described in WAC 182-31-100(1):

(a) An arbitrator; ((~~or~~))

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

(c) A court.

(2) The school employee must pay premium amounts and applicable premium surcharges associated with SEBB ((~~benefits~~)) insurance coverage as premiums and applicable premium surcharges become due. If the monthly premium or applicable premium surcharges remain unpaid for sixty days from the original due date, SEBB ((~~benefits~~)) insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharges were paid as described in WAC 182-30-040 (1)(((~~b~~))) (c).

(3) If the dismissal is upheld, all SEBB ((~~benefits~~)) insurance coverage will ((~~end~~)) terminate at the end of the month in which the decision is entered, or the date to which premiums have been paid, whichever is later, with the exception described in subsection (4) of this section.

(4) If the dismissal is upheld and the school employee is eligible under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), the school employee may continue SEBB medical, dental, vision, or any combination of them for the remaining months available under COBRA. See WAC 182-31-090 for information on COBRA. The number of months the school employee self-paid premiums during the appeal will count toward the total number of months allowed under COBRA.

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

(a) When the employer contribution is reinstated, HCA will refund premiums and applicable premium surcharges the school employee paid only if the school employee retroactively pays their employee contribution amounts for SEBB benefits. In the alternative, at the request of the school employee, HCA may deduct the school employee's contribution amount for SEBB ((~~insurance coverage~~)) benefits from the refund of premiums and applicable premium surcharges self-paid by the school employee during the appeal period.

(b) All supplemental life insurance((~~,~~)) and supplemental accidental death and dismemberment (AD&D) insurance that was in force at the time of dismissal shall be reinstated retroactively only if the school employee makes retroactive payment of premium for any such supplemental coverage that was not continued by self-payment during the appeal process. If the school employee chooses not to pay the retroactive premium, evidence of insurability will be required to ((~~restore~~)) enroll in such supplemental coverage.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-31-130 What options for continuation coverage are available to dependents who cease to meet the eligibility criteria as described in WAC 182-31-140 or 182-30-130? If eligible, dependents may continue ((~~SEBB benefits~~)) health plan enrollment under one of the continuation coverage options in subsection (1) or (2) of this section by self-paying the premiums and applicable premium surcharges set by the health care authority (HCA), with no contribution from the school employees benefits board (SEBB) organization, following their loss of eligibility under the subscriber's ((~~SEBB benefits~~)) health plan coverage. The depen-

dent's first premium payment and applicable premium surcharges are due ((~~to the HCA~~)) no later than forty-five days after the dependent's election ((~~is received by the SEBB program~~)) period ends as described in WAC 182-31-090 or 182-12-265, whichever applies. Premiums and applicable premium surcharges associated with continuing SEBB medical, must be made to the HCA as well as premiums associated with continuing SEBB dental or SEBB vision insurance coverage. Following the dependent's first premium payment, the dependent must pay premium and applicable premium ((~~surcharge amounts associated with SEBB benefits as premiums and applicable premium~~)) surcharges as they become due. If the monthly premium or applicable premium surcharges remain unpaid for sixty days from the original due date, SEBB ((~~benefits~~)) insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharges were paid as described in WAC 182-30-040 (1)(((~~(b)~~))) (c). The SEBB program must receive the required forms as outlined in the SEBB initial notice of COBRA and continuation coverage rights. Options for continuing health plan enrollment are based on the reason that eligibility was lost.

(1) Dependents who lose eligibility due to the death of ((~~an~~)) a school employee may be eligible to continue health plan enrollment as described in WAC ((~~182-12-180 or~~)) 182-12-265; or

(2) Dependents who lose eligibility because they no longer meet the eligibility criteria as described in WAC 182-31-140 are eligible to continue SEBB ((~~benefits enrollment~~)) medical, dental, or vision under provisions of the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). See WAC 182-31-090 for more information on COBRA.

(3) A subscriber's state registered domestic partner and the state registered domestic partner's children may continue SEBB medical, dental, or vision on the same terms and conditions as spouses and other eligible dependents under COBRA as described under RCW 26.60.015.

(4) No continuation coverage will be offered unless the SEBB program is notified through hand delivery or United States Postal Service mail of the qualifying event as outlined in the SEBB initial notice of COBRA and continuation coverage rights.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-31-135 Where may school employee survivors go for additional coverage options? A school employee's spouse, state registered domestic partner, or child who loses eligibility for the employer contribution toward school employees benefits board (SEBB) ((~~insurance~~)) benefits due to the death of an eligible school employee may be eligible to enroll in or defer enrollment as a survivor under public employees benefits board (PEBB) retiree insurance coverage as described in WAC 182-12-265 rather than enrolling in continuation coverage.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-31-140 Who are eligible dependents? To be enrolled in SEBB ((~~benefits~~)) health plan coverage, a dependent must be eligible under this section and the subscriber must comply with enrollment procedures outlined in WAC 182-31-150.

The school employees benefits board (SEBB) program verifies the eligibility of all dependents and will request documents from subscribers that provide evidence of a dependent's eligibility. The SEBB program reserves the right to review a dependent's eligibility at any time. The SEBB program will remove a subscriber's enrolled dependents from health plan ((~~enrollment~~)) coverage if the SEBB program is unable to verify a dependent's eligibility. ((~~The SEBB program and SEBB organizations~~)) A dependent will not ((~~enroll dependents into SEBB benefits if they are~~)) be enrolled in SEBB health plan coverage if the SEBB program or the SEBB organization is unable to verify ((~~a~~)) the dependent's eligibility within the SEBB program enrollment timelines.

The subscriber must provide notice, in writing, when their dependent is not eligible under this section as described in WAC 182-31-150 (2)(a). ((~~A school employee must notify their SEBB organization, except as required in subsection (3)(h)(ii) of this section. A subscriber on continuation coverage must notify the SEBB program. The notification must be received no later than sixty days after the date their dependent is no longer eligible under this section. See WAC 182-31-150(2) for the consequences of not removing an ineligible dependent from SEBB benefits.~~))

The following are eligible as dependents:

(1) Legal spouse. A former spouse is not an eligible dependent upon finalization of a divorce or annulment, even if a court order requires the subscriber to provide health insurance for the former spouse;

(2) State registered domestic partner. A former state registered domestic partner is not an eligible dependent upon dissolution or termination of a partnership, even if a court order requires the subscriber to provide health insurance for the former partner;

(3) Children. Children are eligible through the last day of the month in which their twenty-sixth birthday occurred except as described in (f) of this subsection. Children are defined as the subscriber's:

(a) Children based on establishment of a parent-child relationship as described in RCW 26.26A.100, except when parental rights have been terminated;

(b) Children of the subscriber's spouse, based on the spouse's establishment of a parent-child relationship, except when parental rights have been terminated. The stepchild's relationship to the subscriber (and eligibility as a dependent) ends on the same date the marriage with the spouse ends through divorce, annulment, dissolution, termination, or death;

(c) Children of the subscriber's state registered domestic partner, based on the state registered domestic partner's establishment of a parent-child relationship, except when parental rights have been terminated. The child's relationship to the subscriber (and eligibility as a dependent) ends on the same date the subscriber's legal relationship with the state

registered domestic partner ends through divorce, annulment, dissolution, termination, or death;

(d) Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child;

(e) Children specified in a court order or divorce decree for whom the subscriber has a legal obligation to provide support or health care coverage;

(f) Children of any age with a developmental or physical disability that renders the child incapable of self-sustaining employment and chiefly dependent upon the subscriber for support and maintenance provided such condition occurs before the age of twenty-six:

(i) The subscriber must provide proof of the disability and dependency within sixty days of the child's attainment of age twenty-six;

(ii) The subscriber must notify the SEBB program, in writing, ((~~no later than sixty days after the date that~~)) when the child is no longer eligible under this subsection as described in WAC 182-31-150 (2)(a);

(iii) A child with a developmental or physical disability who becomes self-supporting is not eligible under this subsection as of the last day of the month in which they become capable of self-support;

(iv) A child with a developmental or physical disability age twenty-six and older who becomes capable of self-support does not regain eligibility if they later become incapable of self-support; and

(v) The SEBB program with input from the applicable contracted vendor will periodically verify the eligibility of a dependent child with a disability beginning at age twenty-six, but no more frequently than annually after the two-year period following the child's twenty-sixth birthday((~~, which may~~)). Verification will require renewed proof of disability and dependence from the subscriber.

(g) Extended dependent in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or the subscriber's state registered domestic partner. The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. Extended dependent child does not include a foster child unless the subscriber, the subscriber's spouse, or the subscriber's state registered domestic partner has assumed a legal obligation for total or partial support in anticipation of adoption.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-31-150 When may subscribers enroll or remove eligible dependents? (1) **Enrolling dependents in school employees benefits board (SEBB) ((~~benefits~~)) health plan coverage and the effective date of supplemental dependent life insurance and accidental death and dismemberment (AD&D) insurance.** A dependent must be enrolled in the same health plan coverage as the subscriber, and the subscriber must be enrolled ((~~in a medical plan~~)) to enroll their dependent. Subscribers must satisfy the enrollment requirements as described in subsection (4) of this section and may enroll eligible dependents at the following times:

(a) **When the subscriber becomes eligible** and enrolls in SEBB benefits. If eligibility is verified ((~~and the dependent is enrolled,~~)) the dependent's effective date will be as follows:

(i) SEBB health plan coverage will be the same as the subscriber's effective date((~~, except if the subscriber enrolls a newborn child in supplemental dependent life insurance. The newborn child's dependent life insurance coverage or AD&D insurance will be effective on the date the child becomes fourteen days old~~));

(ii) Supplemental dependent life or AD&D insurance, if elected, will be effective the first day of the month following the date the contracted vendor receives the required form or approves the enrollment. A newly born child must be at least fourteen days old before supplemental dependent life insurance or AD&D insurance coverage is effective.

(b) **During the annual open enrollment.** SEBB ((~~benefits~~)) health plan coverage begins January 1st of the following year; ((~~or~~))

(c) **During special open enrollment.** Subscribers may enroll dependents during a special open enrollment as described in subsection((~~s (3) and (5)(f)~~)) (3) of this section;

(d) **When a National Medical Support Notice (NMSN)** requires a subscriber to cover a dependent child as described in WAC 182-31-160; or

(e) **Any time during the calendar year for supplemental dependent life insurance or AD&D insurance** by submitting the required form to the contracted vendor for approval. Evidence of insurability may be required for supplemental dependent life insurance but will not be required for supplemental AD&D insurance.

(2) **Removing dependents from ((~~a subscriber's~~)) SEBB health plan coverage or supplemental dependent life insurance or AD&D insurance.**

(a) **A dependent's eligibility for enrollment in SEBB health plan coverage or supplemental dependent life insurance or AD&D insurance ends the last day of the month the dependent** meets the eligibility criteria as described in WAC 182-31-140. Subscribers must provide notice when a dependent is no longer eligible due to divorce, annulment, dissolution, or qualifying event of dependent ceasing to be eligible as a dependent child as described in WAC 182-31-140(3). The notice must be received within sixty days of the last day of the month the dependent loses eligibility for SEBB health plan coverage. School employees must notify their SEBB organization when a dependent is no longer eligible except as required under WAC 182-31-140 (3)(f)(ii). All other subscribers must notify the SEBB program. Consequences for not submitting notice within the required sixty days ((~~of the last day of the month the dependent loses eligibility for health plan coverage may~~)) include, but are not limited to:

(i) The dependent may lose eligibility to continue ((~~health plan coverage~~)) SEBB medical, dental, or vision under one of the continuation coverage options described in WAC 182-31-130;

(ii) The subscriber may be billed for claims paid by the health plan for services that were rendered after the dependent lost eligibility as described in WAC 182-31-130;

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

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

(b) **School employees have the opportunity to remove eligible dependents:**

(i) During the annual open enrollment. The dependent will be removed from SEBB health plan coverage the last day of December; ((~~or~~))

(ii) During a special open enrollment as described in subsections (3) and ((~~(5)~~)) (4)(f) of this section;

(iii) When a NMSN requires a spouse, former spouse, or other individual to provide health plan coverage for a dependent who is already enrolled in SEBB coverage, and that health plan coverage is in fact provided as described in WAC 182-31-160(2); or

(iv) Any time during the calendar year from supplemental dependent life or AD&D insurance by submitting the required form to the contracted vendor.

(c) **Enrollees with SEBB continuation coverage as described in WAC 182-31-090 and 182-31-100 may remove dependents** from their SEBB ((~~benefits~~)) health plan coverage outside of the annual open enrollment or a special open enrollment by providing written notice to the SEBB program. The dependent will be removed from the subscriber's SEBB ((~~benefits~~)) health plan coverage prospectively. SEBB ((~~benefits~~)) health plan coverage will end on the last day of the month in which the written notice is received by the SEBB program or on the last day of the month specified in the subscriber's written notice, whichever is later. If the written notice is received on the first day of the month, SEBB health plan coverage will end on the last day of the previous month. SEBB continuation coverage enrollees may remove supplemental dependent life or AD&D insurance any time during the calendar year by submitting the required form to the contracted vendor.

(3) **Special open enrollment.**

(a) Subscribers may enroll or remove their eligible dependents outside of the annual open enrollment if a special open enrollment event occurs. The change in enrollment must be allowable under the Internal Revenue Code and Treasury regulations, and correspond to and be consistent with the event that creates the special open enrollment for the subscriber, the subscriber's dependents, or both.

(i) SEBB ((~~benefits~~)) health plan coverage will begin the first of the month following the later of the event date or the date the required form is received. If that day is the first of the month, the change in enrollment begins on that day.

(ii) ((~~Enrollment of~~)) SEBB health plan coverage for an extended dependent or a dependent with a disability will ((~~be~~)) begin the first day of the month following the later of the event date ((~~as described in WAC 182-31-140(3)~~)) or eligibility certification.

(iii) The dependent will be removed from the subscriber's SEBB ((~~benefits~~)) health plan coverage the last day of the month following the later of the event date or the date the required form and proof of the event is received. If that day is the first of the month, the change in enrollment will be made the last day of the previous month.

(iv) If the special open enrollment is due to the birth or adoption of a child, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of a child, SEBB ((~~benefits~~)) health plan coverage will begin or end as follows:

• For the newly born child, SEBB ((~~benefits~~)) health plan coverage will begin the date of birth;

• For a newly adopted child, SEBB ((~~benefits~~)) health plan coverage will begin on the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier;

• For a spouse or state registered domestic partner of a subscriber, SEBB health plan coverage will begin the first day of the month in which the event occurs. The spouse or state registered domestic partner will be removed from SEBB health plan coverage the last day of the month in which the event occurred((~~;~~

~~A newly born child must be at least fourteen days old before supplemental dependent life insurance coverage or accidental death and dismemberment insurance purchased by the employee becomes effective~~)).

(b) Any one of the following events may create a special open enrollment:

((~~(b)~~)) (i) Subscriber acquires a new dependent due to:

((~~(i)~~)) • Marriage or registering a state registered domestic partnership;

((~~(ii)~~)) • Birth, adoption, or when a subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or

((~~(iii)~~)) • A child becoming eligible as an extended dependent through legal custody or legal guardianship.

((~~(c)~~)) (ii) Subscriber or a subscriber's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);

((~~(d)~~)) (iii) Subscriber has a change in employment status that affects the subscriber's eligibility for their employer contribution toward their employer-based group health plan;

((~~(e)~~)) (iv) The subscriber's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan;

Note: As used in ((~~(e)~~)) (iv) of this subsection "employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 54.9801-6.

((~~(f)~~)) (v) Subscriber or a subscriber's dependent has a change in enrollment under an employer-based group health plan during its annual open enrollment that does not align with the SEBB program's annual open enrollment;

((~~(g)~~)) (vi) Subscriber's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States and that change in residence results in the dependent losing their health insurance;

((~~(h)~~)) (vii) A court order requires the subscriber or any other individual to provide insurance coverage for an eligible

dependent of the subscriber (a former spouse or former state registered domestic partner is not an eligible dependent);

((~~(i)~~)) (viii) Subscriber or a subscriber's dependent ((~~becomes entitled to~~)) enrolls in coverage under medicaid or a state children's health insurance program (CHIP), or the subscriber or a subscriber's dependent loses eligibility for coverage under medicaid or CHIP;

((~~(j)~~)) (ix) Subscriber or a subscriber's dependent becomes eligible for state premium assistance subsidy for SEBB health plan coverage from medicaid or CHIP.

(4) **Enrollment requirements. A subscriber must submit the required forms within the time frames described in this subsection.** For SEBB health plan coverage, a school employee must submit the required forms to their SEBB organization, a subscriber on continuation coverage must submit the required forms to the SEBB program. In addition to the required forms indicating dependent enrollment, the subscriber must provide the required documents as evidence of the dependent's eligibility; or as evidence of the event that created the special open enrollment. All required forms and documents must be received within the required time frames. A school employee enrolling a dependent in supplemental life insurance or AD&D insurance must submit the required form to the contracted vendor for approval within the required time frames.

(a) If a subscriber wants to enroll their eligible dependents in SEBB health plan coverage or supplemental dependent life or AD&D insurance when the subscriber becomes eligible to enroll in SEBB benefits, the subscriber must include the dependent's enrollment information on the required forms and submit them within the required time frame as described in WAC 182-30-060 and 182-30-080.

(b) If a subscriber wants to enroll eligible dependents in SEBB health plan coverage during the SEBB annual open enrollment period, the required forms must be received no later than the last day of the annual open enrollment.

(c) If a subscriber wants to enroll newly eligible dependents, the required forms must be received no later than sixty days after the dependent becomes eligible. A school employee enrolling a dependent in supplemental life insurance or AD&D insurance must submit the required form to the contracted vendor for approval. A school employee may enroll a dependent in supplemental life insurance up to the guaranteed issue coverage amount without evidence of insurability if the required form is submitted to the contracted vendor as required. Evidence of insurability will be required for supplemental dependent life insurance over the guaranteed issue coverage amount. Evidence of insurability is not required for supplemental AD&D insurance.

(d) If a subscriber wants to enroll a newborn or child whom the subscriber has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption in SEBB health plan coverage, the subscriber should notify the SEBB program by submitting the required forms as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the required forms must be received no later than sixty days after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption. A school employee enrolling a dependent in supplemental life insurance or AD&D insurance must submit the required form to the contracted vendor for approval. A newly born child must be at least fourteen days old before supplemental dependent life insurance or AD&D insurance coverage can become effective.

(e) If the subscriber wants to enroll a child age twenty-six or older as a child with a disability in SEBB health plan coverage, the required forms must be received no later than sixty days after the ((~~last day of the month in which the~~)) child reaches age twenty-six or within the relevant time frame described in ((~~WAC 182-31-140 (3)~~)) (a), (b), and (f) of this subsection. To recertify an enrolled child with a disability, the required forms must be received by the SEBB program or the contracted vendor by the child's scheduled SEBB health plan coverage termination date.

(f) If the subscriber wants to change a dependent's enrollment status in SEBB health plan coverage during a special open enrollment, the required forms must be received no later than sixty days after the event that creates the special open enrollment.

(g) A school employee may enroll a dependent in supplemental life insurance or AD&D insurance at any time during the calendar year by submitting the required form to the contracted vendor for approval. Evidence of insurability may be required for supplemental dependent life insurance but will not be required for supplemental AD&D insurance.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-31-160 National Medical Support Notice (NMSN). (1) When a National Medical Support Notice (NMSN) requires a subscriber to provide health plan coverage for a dependent child the following provisions apply:

(a) The subscriber may enroll their dependent child and request changes to their health plan coverage as described under (c) of this subsection. School employees submit the required forms to their school employees benefits board (SEBB) organization. Subscribers on continuation coverage submit the required forms to the SEBB program;

(b) If the subscriber fails to request enrollment or health plan coverage changes as directed by the NMSN, the SEBB organization or the SEBB program may make enrollment or health plan coverage changes according to (c) of this subsection upon request of:

(i) The child's other parent; or

(ii) Child support enforcement program.

(c) Changes to health plan coverage or enrollment are allowed as directed by the NMSN:

(i) The dependent will be enrolled under the subscriber's health plan coverage as directed by the NMSN;

(ii) A school employee who has waived SEBB medical as described in WAC 182-31-080 will be enrolled in medical as directed by the NMSN, in order to enroll the dependent;

(iii) The subscriber's selected health plan will be changed if directed by the NMSN;

(iv) If the dependent is already enrolled under another SEBB subscriber, the dependent will be removed from the other health plan coverage and enrolled as directed by the NMSN; or

(v) If the subscriber is eligible for and elects Consolidated Omnibus Budget Reconciliation Act (COBRA) or other continuation coverage, the NMSN will be enforced and the dependent must be covered in accordance with the NMSN.

(d) Changes to health plan coverage or enrollment as described in (c)(i) through (iii) of this subsection will begin the first day of the month following receipt by the SEBB organization of the NMSN. If the NMSN is received by the SEBB organization on the first day of the month, the change to health plan coverage or enrollment begins on that day. A dependent will be removed from the subscriber's health plan coverage as described in (c)(iv) of this subsection the last day of the month the NMSN is received. If that day is the first of the month, the change in enrollment will be made the last day of the previous month.

(2) When a NMSN requires a spouse, former spouse, or other individual to provide health plan coverage for a dependent who is already enrolled in SEBB coverage, and that health plan coverage is in fact provided, the dependent may be removed from the subscriber's SEBB ((~~insurance~~)) health plan coverage prospectively.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-31-190 School employees benefits board (SEBB) wellness incentive program eligibility and procedural requirements. The ((~~school employees benefits board (SEBB)~~)) board annually determines the design of the SEBB wellness incentive program.

(1) All subscribers are eligible to participate in the SEBB wellness incentive program.

(2) ((~~For plan year 2020, all subscribers that register in SmartHealth and complete the well-being assessment during the 2019 open enrollment will earn a $50 incentive as a reduction in their SEBB medical deductible or a deposit into their SEBB health savings account (HSA).~~

~~(3)~~)) Effective January 1, 2020, to receive the SEBB wellness incentive of a reduction to the subscriber's medical plan deductible or a deposit to the subscriber's health savings account for the following plan year, eligible subscribers must complete SEBB wellness incentive program requirements during the current plan year by the following deadline:

(a) For subscribers continuing enrollment in SEBB medical and subscribers enrolling in SEBB medical with an effective date in January through September, the deadline is November 30th; or

(b) For subscribers enrolling in SEBB medical with an effective date in October through December, the deadline is December 31st.

(((~~(4)~~))) (3) Subscribers who do not complete the requirements according to subsection (((~~(3)~~))) (2) of this section within the time frame described are not eligible to receive a SEBB wellness incentive the following plan year.

Note: All eligible subscribers can earn a wellness incentive. Subscribers who cannot complete the wellness incentive program requirements may be able to earn the same incentive by different means. The ((~~SEBB program~~)) contracted vendor will work with enrollees (and their physician, if they wish) to define an individual wellness program that provides the opportunity to qualify for the same incentive in light of the enrollee's health status.

(((~~(5)~~))) (4) A SEBB wellness incentive will be provided only if:

(a) For the wellness incentive described in subsection (((~~(3)~~))) (2) of this section the subscriber is still eligible for the SEBB wellness incentive program and is enrolled in a SEBB medical plan in the year the incentive applies;

(b) The funding rate provided by the legislature is designed to provide a SEBB wellness incentive program or a SEBB wellness incentive, or both; or

(c) Specific appropriations are provided for wellness incentives.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 182-31-091	School employees benefits boards (SEBB) continuation coverage for school employees and their dependents who are not eligible for SEBB benefits as of January 1, 2020, and for dependents who were already on a SEBB organization's continuation coverage as of December 31, 2019?

AMENDATORY SECTION (Amending WSR 19-01-055, filed 12/14/18, effective 1/14/19)

WAC 182-32-010 Purpose. This chapter describes the general rules and procedures that apply to the health care authority's brief adjudicative proceedings and formal administrative hearings for the school employees benefits board (((~~SEBB~~))) program.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-020 Definitions. The following definitions apply throughout this chapter unless the context clearly indicates another meaning:

"Accidental death and dismemberment insurance" or "AD&D" means basic accidental death and dismemberment (AD&D) insurance paid for by the SEBB organization((~~s~~)), as well as supplemental accidental death and dismemberment insurance offered to and paid for by school employees for themselves and their dependents.

"Appellant" means a person who requests a brief adjudicative proceeding with the SEBB appeals unit about the action of the SEBB organization, the HCA, or its contracted vendor.

"Authority" or "HCA" means the Washington state health care authority.

"Board" means the school employees benefits board established under provisions of RCW 41.05.740.

"Brief adjudicative proceeding" means the process described in RCW 34.05.482 through 34.05.494 and in WAC 182-32-2000 through 182-32-2160.

"Business days" means all days except Saturdays, Sundays, and all state legal holidays as set forth in RCW 1.16.050.

"Calendar days" or "days" means all days including Saturdays, Sundays, and all state legal holidays as set forth in RCW 1.16.050.

"Continuance" means a change in the date or time of when a brief adjudicative proceeding or formal administrative hearing will occur.

"Contracted vendor" means any person, persons, or entity under contract or agreement with the HCA to provide goods or services for the provision or administration of SEBB benefits. The term "contracted vendor" includes subcontractors of the HCA and subcontractors of any person, persons, or entity under contract or agreement with the HCA that provide goods or services for the provision or administration of SEBB benefits.

"Denial" or "denial notice" means an action by, or communication from, a school employees benefits board (SEBB) organization, contracted vendor, or the SEBB program that aggrieves a subscriber, a dependent, or an applicant, with regard to SEBB benefits including, but not limited to, actions or communications expressly designated as a "denial," "denial notice," or "cancellation notice."

"Dependent" means a person who meets eligibility requirements in WAC 182-31-140.

"Dependent care assistance program" or "DCAP" means a benefit plan whereby school employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan under chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 129 or other sections of the Internal Revenue Code.

"Director" means the director of the authority.

"Disability insurance" includes any basic long-term disability insurance paid for by the school employees benefits board (SEBB) organization and any supplemental long-term disability or supplemental short-term disability paid for by the school employee.

"Dispositive motion" is a motion made to a presiding officer, review officer, or hearing officer to decide a claim or case in favor of the moving party without further proceedings.

"Documents" means papers, letters, writings, electronic mail, electronic files, or other printed or written items.

"Employer-based group ((~~health plan~~)) medical" means group medical((~~, group vision, and group dental~~)) related to a current employment relationship. It does not include medical((~~, vision, or dental~~)) coverage available to retired employees, individual market medical ((~~or dental~~)) coverage((~~, or governmental sponsored~~)) or government-sponsored programs such as medicare or medicaid.

"Enrollee" means a person who meets all eligibility requirements defined in chapter 182-31 WAC or WAC 182-30-130, who is enrolled in SEBB benefits, and for whom applicable premium payments have been made.

"File" or "filing" means the act of delivering documents to the office of the presiding officer, review officer, or hearing officer. A document is considered filed when it is received by the ((~~health care~~)) authority or its designee.

"Final order" means an order that is the final health care authority decision.

"Formal administrative hearing" means a proceeding before a hearing officer that gives an appellant an opportunity for an evidentiary hearing as described in RCW 34.05.413 through 34.05.476 and WAC 182-32-3000 through 182-32-3200.

"HCA hearing representative" means a person who is authorized to represent the SEBB program in a formal administrative hearing. The person may be an assistant attorney general or authorized HCA employee.

"Health plan" means a plan offering medical, vision, dental, or any combination of these coverages, developed by the ((~~SEBB~~)) board and provided by a contracted vendor or self-insured plans administered by the HCA.

"Hearing officer" means an impartial decision maker who presides at a formal administrative hearing, and is:

• A director-designated HCA employee; or

• When the director has designated the office of administrative hearings (OAH) as a hearing body, an administrative law judge employed by the OAH.

"Life insurance" means any basic life insurance paid for by the SEBB organization, as well as supplemental life insurance offered to and paid for by school employees for themselves and their dependents.

"Long-term disability insurance" or "LTD insurance" ((~~or "long-term disability insurance" includes~~)) means basic long-term disability insurance paid for by the SEBB organization and supplemental long-term disability insurance offered to and paid for by the school employee.

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby eligible school employees may reduce their salary before taxes to pay for medical expenses not reimbursed by insurance as provided in the salary reduction plan established under chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"PEBB" means the public employees benefits board.

"Prehearing conference" means a proceeding scheduled and conducted by a hearing officer to address issues in preparation for a formal administrative hearing.

"Premium payment plan" means a benefit plan whereby school employees may pay their share of group health plan premiums with pretax dollars as provided in the salary reduction plan under chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"Premium surcharge" means a payment required from a subscriber, in addition to the subscriber's medical premium contribution, due to an enrollee's tobacco use or an enrolled subscriber's spouse or state registered domestic partner choosing not to enroll in their employer-based group medical when:

• The spouse's or state registered domestic partner's share of the medical premiums is less than ninety-five percent of

the additional cost an employee would be required to pay to enroll a spouse or state registered domestic partner in the public employees benefits board (PEBB) Uniform Medical Plan (UMP) Classic; and

• The benefits have an actuarial value of at least ninety-five percent of the actuarial value of PEBB UMP Classic benefits.

"Presiding officer" means an impartial decision maker who conducts a brief adjudicative proceeding and is a director-designated HCA employee.

((~~"Public employees benefits board" or "PEBB" means the board established under provisions of RCW 41.05.055.~~))

"Review officer or officers" means one or more delegates from the director that consider appeals relating to the administration of SEBB benefits by the SEBB program.

"Salary reduction plan" means a benefit plan whereby school employees may agree to a reduction of salary on a pretax basis to participate in the dependent care assistance program (((~~(DCAP)~~))), medical flexible spending arrangement (((~~(FSA)~~))), or premium payment plan offered pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"School employee" means:

• All employees of school districts and charter schools established under chapter 28A.710 RCW;

• Represented employees of educational service districts; and

• Effective January 1, 2024, all employees of educational service districts.

"School employees benefits board organization" or "SEBB organization" means a public school district or educational service district or charter school established under chapter 28A.710 RCW that is required to participate in benefit plans provided by the school employees benefit board.

"SEBB" means the school employees benefits board ((~~established in RCW 41.05.740~~)).

"SEBB benefits" means one or more insurance coverages or other employee benefits administered by the SEBB program within the HCA.

"SEBB insurance coverage" means any health plan, life insurance, accidental death and dismemberment insurance, or long-term disability insurance administered as a SEBB benefit.

"SEBB program" means the program within the HCA that administers insurance and other benefits for eligible school employees (as described in WAC 182-31-040 or 182-30-130), and eligible dependents (as described in WAC 182-31-140).

"State registered domestic partner," has the same meaning as defined in RCW 26.60.020(1) and substantially equivalent legal unions from other jurisdictions as defined in RCW 26.60.090.

"Subscriber" means the school employee or continuation coverage enrollee who has been determined eligible by the SEBB program or SEBB organizations, is enrolled in SEBB benefits, and is the individual to whom the SEBB program and contracted vendors will issue all notices, information, requests, and premium bills on behalf of an enrollee.

"Tobacco products" means any product made with or derived from tobacco that is intended for human consumption, including any component, part, or accessory of a tobacco product. This includes, but is not limited to, cigars, cigarettes, pipe tobacco, chewing tobacco, snuff, and other tobacco products. It does not include e-cigarettes or United States Food and Drug Administration (FDA) approved quit aids.

"Tobacco use" means any use of tobacco products within the past two months. Tobacco use, however, does not include the religious or ceremonial use of tobacco.

AMENDATORY SECTION (Amending WSR 19-01-055, filed 12/14/18, effective 1/14/19)

WAC 182-32-058 Service or serve. (1) When the rules in this chapter or in other school employees benefits board (SEBB) program rules or statutes require a party to serve copies of documents on other parties, a party must send copies of the documents to all other parties or their representatives as described in this chapter. In this section, requirements for service or delivery by a party apply also when service is required by the presiding officer or review officer or officers, or hearing officer.

(2) Unless otherwise stated in applicable law, documents may be sent only as identified in this chapter to accomplish service. A party may serve someone by:

(a) Personal service (hand delivery);

(b) First class, registered, or certified mail sent via the United States Postal Service or Washington state consolidated mail services;

(c) Fax;

(d) Commercial delivery service; or

(e) Legal messenger service.

(3) A party must serve all other parties or their representatives whenever the party files a motion, pleading, brief, or other document with the presiding officer, review officer or officers, or hearing officer's office, or when required by law.

(4) Service is complete when:

(a) Personal service is made;

(b) Mail is properly stamped, addressed, and deposited in the United States Postal Service;

(c) Mail is properly addressed, and deposited in the Washington state consolidated mail services;

(d) Fax produces proof of transmission;

(e) A parcel is delivered to a commercial delivery service with charges prepaid; or

(f) A parcel is delivered to a legal messenger service with charges prepaid.

(5) A party may prove service by providing any of the following:

(a) A signed affidavit of mailing or certificate of ((~~mailing~~)) service;

(b) The certified mail receipt signed by the person who received the parcel;

(c) A signed receipt from the person who accepted the commercial delivery service or legal messenger service parcel;

(d) Proof of fax transmission.

(6) Service cannot be made by electronic mail unless mutually agreed to in advance and in writing by the parties.

(7) If the document is a subpoena, follow the compliance procedure as described in WAC 182-32-3130.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-066 Burden of proof, standard of proof, and presumptions. (1) The burden of proof is a party's responsibility to provide evidence regarding disputed facts and persuade the presiding officer, review officer or officers, or hearing officer that a position is correct based on the standard of proof. Unless stated otherwise in rules or law, the appellant has the burden of proof in a brief adjudicative proceeding or formal administrative hearing.

(2) Standard of proof refers to the ((~~degree or level of proof~~)) amount of evidence needed to prove a party's position. Unless stated otherwise in rules or law, the standard of proof in a brief adjudicative proceeding or formal administrative hearing is a preponderance of the evidence, meaning that something is more likely to be true than not.

(3) Public officers and school employees benefits board (SEBB) organizations are presumed to have properly performed their duties and acted as described in the law, unless substantial evidence to the contrary is presented. A party challenging this presumption bears the burden of proof.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-120 Computation of time. (1) In computing any period of time prescribed by this chapter, the day of the event from which the time begins to run is not included. (For example, if an initial order is served on Friday and the party has twenty-one days to request a review, start counting the days with Saturday.)

(2) As provided in subsection (3) of this section, the last day of the period so computed is included unless it is a Saturday, Sunday, or legal holiday as defined in RCW 1.16.050, in which case the period extends to ((~~the end of~~)) the next business day.

(3) When the period of time prescribed or allowed is ten days or less, intermediate Saturdays, Sundays and state legal holidays ((~~shall~~)) must be excluded in the computation.

(4) The deadline is 5:00 p.m. on the last day of the computed period.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-130 Index of significant decisions. (1) A final ((~~decision~~)) order may be relied upon, used, or cited as precedent by a party only if the final order has been indexed in the authority's index of significant decisions in accordance with RCW 34.05.473 (1)(b).

(2) An index of significant decisions is available to the public on the health care authority's (HCA) website. As decisions are indexed they will be available on the website.

(3) A final ((~~decision~~)) order published in the index of significant decisions may be removed from the index when:

(a) A published decision entered by the court of appeals or the supreme court reverses an indexed final ((~~decision~~)) order; or

(b) HCA determines that the indexed final ((~~decision~~)) order is no longer precedential due to changes in statute, rule, or policy.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-2010 Appealing a decision regarding school employees benefits board (SEBB) eligibility, enrollment, premium payments, premium surcharges, a wellness incentive, or the administration of benefits. (1) Any current or former school employee of a school employees benefits board (SEBB) organization or their dependent aggrieved by a decision made by the SEBB organization with regard to SEBB eligibility, enrollment, or premium surcharges may appeal that decision to the SEBB organization by the process described in WAC 182-32-2020.

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

(2) Any subscriber or dependent aggrieved by a decision made by the SEBB program with regard to SEBB eligibility, enrollment, premium payments, ((~~or~~)) premium surcharges, eligibility to participate in the SEBB wellness incentive program, or eligibility to receive the SEBB wellness incentive, may appeal that decision to the SEBB appeals unit by the process described in WAC 182-32-2030.

(3) Any enrollee aggrieved by a decision regarding the administration of ((~~a health plan~~)) SEBB medical, dental, and vision, life insurance, accidental death and dismemberment (AD&D) insurance, or disability insurance, may appeal that decision by following the appeal provisions of those plans, with the exception of:

(a) Enrollment decisions;

(b) Premium payment decisions other than life insurance or AD&D insurance premium payment decisions; and

(c) Eligibility decisions.

(4) Any SEBB enrollee aggrieved by a decision regarding the administration of SEBB property and casualty insurance may appeal that decision by following the appeal provisions of those plans.

(5) Any school employee aggrieved by a decision regarding the administration of a benefit offered under the salary reduction plan may appeal that decision by the process described in WAC 182-32-2050.

(6) Any subscriber aggrieved by a decision made by the SEBB wellness incentive program contracted vendor regarding the completion of the SEBB wellness incentive program requirements, or a request for a reasonable alternative to a wellness incentive program requirement, may appeal that decision by the process described in WAC 182-32-2040.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-2020 Appealing a decision made by a school employees benefits board (SEBB) organization about eligibility, premium surcharges, or enrollment in benefits. (1) An eligibility, premium surcharges, or enrollment decision made by a school employees benefits board (SEBB) organization may be appealed by submitting a written request for administrative review to the SEBB organization. The SEBB organization must receive the request for administrative review no later than thirty days after the date of the denial notice. The contents of the request for administrative review are to be provided as described in WAC 182-32-2070.

(a) Upon receiving the request for administrative review, the SEBB organization must perform a complete review of the denial by one or more staff who did not take part in the decision resulting in the denial.

(b) The SEBB organization must render a written decision within thirty days of receiving the written request for administrative review. The written decision must be sent to the school employee or school employee's dependent who submitted the request for administrative review and must include a description of the appeal rights. The SEBB organization must also send a copy of the SEBB organization's written decision to the SEBB organization's administrator (or designee) and to the SEBB appeals unit. If the SEBB organization fails to render a written decision within thirty days of receiving the written request for administrative review, the request for administrative review may be considered denied as of the ((~~thirtieth~~)) thirty-first day and the original underlying SEBB organization decision may be appealed to the SEBB appeals unit by following the process in this section.

(c) The SEBB organization may reverse eligibility, premium surcharges, or enrollment decisions as permitted by WAC 182-30-060.

(2) Any current or former school employee or school employee's dependent who disagrees with the SEBB organization's decision in response to a written request for administrative review, as described in subsection (1) of this section, may request a brief adjudicative proceeding to be conducted by the authority by submitting a written request to the SEBB appeals unit.

(a) The SEBB appeals unit must receive the request for a brief adjudicative proceeding no later than thirty days after the date of the SEBB organization's written decision on the request for administrative review. If the SEBB organization fails to render a written decision within thirty days of receiving a written request for administrative review, the SEBB appeals unit must receive the request for a brief adjudicative proceeding no later than thirty days after the date the request for administrative review was deemed denied. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-32-2070.

(i) The SEBB appeals unit must notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(ii) Once the SEBB appeals unit receives a request for a brief adjudicative proceeding, the SEBB appeals unit will send a request for documentation and information to the applicable SEBB organization. The SEBB organization will then have two business days to respond to the request and provide the requested documentation and information. The SEBB organization will also send a copy of the documentation and information to the appellant.

(iii) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(b) If a school employee fails to timely request a brief adjudicative proceeding ((~~to appeal the SEBB organization's written decision within thirty days by following the process in subsection (2) of this section~~)), the SEBB organization's prior written decision becomes the authority's final ((~~decision~~)) order without further action.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-2030 Appealing a school employees benefits board (SEBB) program decision regarding eligibility, enrollment, premium payments, premium surcharges, and a SEBB wellness incentive. (1) A decision made by the school employees benefits board (SEBB) program regarding eligibility, enrollment, premium payments, premium surcharges, or a SEBB wellness incentive may be appealed by submitting a request to the SEBB appeals unit for a brief adjudicative proceeding to be conducted by the authority.

(2) The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-32-2070.

(3) The request for a brief adjudicative proceeding from a current or former school employee or school employee's dependent must be received by the SEBB appeals unit no later than thirty days after the date of the denial notice.

(4) The request for a brief adjudicative proceeding from a self-pay enrollee or dependent of self-pay enrollee must be received by the SEBB appeals unit no later than sixty days after the date of the denial notice.

(5) The SEBB appeals unit ((~~shall~~)) must notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(6) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(7) Failing to timely request a brief adjudicative proceeding ((~~to appeal a decision made under this section within applicable time frames described in subsections (3) and (4) of this section,~~)) will result in the prior SEBB program decision becoming the authority's final ((~~decision~~)) order without further action.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-2040 How can a subscriber appeal a decision regarding the administration of wellness incentive program requirements? (1) Any subscriber aggrieved by a decision regarding the completion of the wellness incentive program requirements, or request for a reasonable alternative to a wellness incentive program requirement, may appeal that decision to the school employees benefits board (SEBB) wellness incentive program contracted vendor.

(2) Any subscriber who disagrees with a decision in response to an appeal filed with the SEBB wellness incentive program contracted vendor may appeal the decision by submitting a request for a brief adjudicative proceeding to the SEBB appeals unit.

(a) The request for a brief adjudicative proceeding from a current or former school employee must be received by the SEBB appeals unit no later than thirty days after the date of the denial notice. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-32-2070.

(b) The request for a brief adjudicative proceeding from a self-pay subscriber must be received by the SEBB appeals unit no later than sixty days after the date of the denial notice. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-32-2070.

(3) The SEBB appeals unit ((~~shall~~)) must notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(4) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(5) If a subscriber fails to timely request a brief adjudicative proceeding ((~~of a decision made under subsection (1) of this section within thirty days by following the process in WAC 182-32-2020(2)~~)), the decision of the SEBB wellness incentive program contracted vendor becomes the authority's final ((~~decision~~)) order without further action.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-2050 How can a school employee appeal a decision regarding the administration of benefits offered under the salary reduction plan? (1) Any school employee who disagrees with a decision that denies eligibility for, or enrollment in, a benefit offered under the salary reduction plan may appeal that decision by submitting a written request for administrative review to their school employees benefits board (SEBB) organization. The SEBB organization must receive the written request for administrative review no later than thirty days after the date of the decision resulting in denial. The contents of the written request for administrative review are to be provided as described in WAC 182-32-2070.

(a) Upon receiving the written request for administrative review, the SEBB organization ((~~shall~~)) must perform a complete review of the denial by one or more staff who did not take part in the decision resulting in the denial.

(b) The SEBB organization ((~~shall~~)) must render a written decision within thirty days of receiving the written request for administrative review. The written decision ((~~shall~~)) must be sent to the school employee who submitted the written request for review and must include a description of appeal rights. The SEBB organization ((~~shall~~)) must also send a copy of the SEBB organization's written decision to the SEBB organization's administrator (or designee) and to the SEBB appeals unit. If the SEBB organization fails to render a written decision within thirty days of receiving the written request for administrative review, the request for administrative review may be considered denied as of the ((~~thirtieth~~)) thirty-first day and the original underlying SEBB organization decision may be appealed to the SEBB appeals unit by following the process in this section.

(2) Any school employee who disagrees with the SEBB organization's decision in response to a written request for administrative review, as described in this section, may request a brief adjudicative proceeding to be conducted by the authority by submitting a written request to the SEBB appeals unit.

(a) The SEBB appeals unit must receive the request for a brief adjudicative proceeding no later than thirty days after the date of the SEBB organization's written decision on the request for administrative review. If a SEBB organization fails to render a written decision within thirty days of receiving a written request for administrative review, the SEBB appeals unit must receive the request for a brief adjudicative proceeding no later than thirty days after the date the request for administrative review was deemed denied. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-32-2070.

(i) The SEBB appeals unit ((~~shall~~)) must notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(ii) Once the SEBB appeals unit receives a request for a brief adjudicative proceeding, the SEBB appeals unit will send a request for documentation and information to the applicable SEBB organization. The SEBB organization will then have two business days to respond to the request and provide the documentation and information requested. The SEBB organization will also send a copy of the documentation and information to the school employee.

(iii) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(b) If a school employee fails to timely request a brief adjudicative proceeding ((~~to appeal a decision made under this section within thirty days by following the process described in this subsection~~)), the SEBB organization's prior written decision becomes the authority's final ((~~decision~~)) order without further action.

(3) Any school employee aggrieved by a decision regarding a claim for benefits under the medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP) offered under the salary reduction plan may appeal that decision to the ((~~HCA~~)) authority's contracted vendor by following the appeal process of that contracted vendor.

(a) Any school employee who disagrees with a decision in response to an appeal filed with the contracted vendor that administers the medical FSA and DCAP under the salary reduction plan may request a brief adjudicative proceeding by submitting a written request to the SEBB appeals unit. The SEBB appeals unit must receive the request for a brief adjudicative proceeding no later than thirty days after the date of the contracted vendor's appeal decision. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-32-2070.

(i) The SEBB appeals unit ((~~shall~~)) must notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(ii) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(b) If a school employee fails to timely request a brief adjudicative proceeding ((~~to appeal a decision made under this section within thirty days by following the process described in this subsection~~)), the contracted vendor's prior written decision becomes the ((~~health care authority (HCA) final decision~~)) authority's final order without further action.

(4) Any school employee aggrieved by a decision regarding the administration of the premium payment plan offered under the salary reduction plan may request a brief adjudicative proceeding to be conducted by the ((~~HCA~~)) authority by submitting a written request to the SEBB appeals unit for a brief adjudicative proceeding.

(a) The SEBB appeals unit must receive the request for a brief adjudicative proceeding no later than thirty days after the date of the denial notice by the SEBB program. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(i) The SEBB appeals unit ((~~shall~~)) must notify the appellant in writing when the notice of appeal has been received.

(ii) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(b) If a school employee fails to timely request a brief adjudicative proceeding ((~~to appeal a decision made under this section within thirty days by following the process described in this subsection~~)), the SEBB program's prior written decision becomes the authority's final ((~~decision~~)) order without further action.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-2085 Continuances. The presiding officer, review officer or officers may grant, in their sole discretion, a request for a continuance on motion of the appellant, the authority, or on their own ((~~motion~~)). The continuance may be up to thirty calendar days.

AMENDATORY SECTION (Amending WSR 19-01-055, filed 12/14/18, effective 1/14/19)

WAC 182-32-2090 Initial order. Unless a continuance has been granted, within ten days after the school employees benefits board (SEBB) appeals unit receives a request for a brief adjudicative proceeding, the presiding officer ((~~shall~~)) must render a written initial order that addresses the issue or issues raised by the appellant in their appeal. The presiding officer ((~~shall~~)) must serve a copy of the initial order on all parties and the initial order ((~~shall~~)) must contain information on how the appellant may request review of the initial order.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-2100 How to request a review of an initial order resulting from a brief adjudicative proceeding. (1) An appellant who has received an initial order upholding a school employees benefits board (SEBB) organization decision, SEBB program decision, or a decision made by a SEBB program contracted vendor, may request review of the initial order by the authority. The appellant must file a written request for review of the initial order or make an oral request for review of the initial order with the SEBB appeals unit within twenty-one days after service of the initial order. The written or oral request for review of the initial order must be ((~~provided~~)) made by using the contact information included in the initial order. If the appellant fails to request review of the initial order within twenty-one days, the initial order becomes the authority's final order without further action ((~~by the authority~~)).

(2) Upon timely request by the appellant, a review of an initial order will be performed by one or more review officers designated by the director of the authority.

(3) If the appellant has not requested review, the authority may review an order resulting from a brief adjudicative proceeding on its own ((~~motion~~)), and without notice to the parties, but it may not take action on review less favorable to any party than the initial order without giving that party notice and an opportunity to explain that party's view of the matter.

AMENDATORY SECTION (Amending WSR 19-01-055, filed 12/14/18, effective 1/14/19)

WAC 182-32-2110 Final order. (1) A final order issued by the review officer or officers will be ((~~issued~~)) in writing and include a brief statement of the reasons for the decision.

(2) The final order must be ((~~rendered and~~)) served within twenty days of the date of the initial order or of the date the request for review of the initial order was received by the SEBB appeals unit, whichever is later.

(3) The final order will include a notice that reconsideration and judicial review may be available.

(4) A request for review of the initial order is deemed denied if the authority does not issue a final order within twenty days after the request for review of the initial order is filed.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-2120 Request for reconsideration. (1) A request for reconsideration asks the review officer or officers to reconsider the final order because the party believes the review officer or officers made a mistake of law, mistake of fact, or clerical error.

(2) A request for reconsideration must state in writing why the party wants the final order to be reconsidered.

(3) Requests for reconsideration must be filed with the review officer or officers who entered the final order.

(4) If a party files a request for reconsideration:

(a) The review officer or officers must receive the request for reconsideration on or before the tenth business day after the service date of the final order;

(b) The party filing the request must send copies of the request to all other parties; and

(c) Within five business days of receiving a request for reconsideration, the review officer or officers must serve to

all parties a notice that provides the date the request for reconsideration was received.

(5) The other parties may respond to the request for reconsideration. The response must state in writing why the final order should stand. Responses are optional. If a party chooses not to respond, that party will not be prejudiced because of that choice.

(a) Responses to a request for reconsideration must be received by the review officer or officers no later than seven business days after the service date of the review officer or officers' notice as described in subsection (4)(c) of this section, or the response will not be considered.

(b) Service of responses to a request for reconsideration must be made to all parties.

(6) If a party needs more time to file a request for reconsideration or respond to a request for reconsideration, the review officer or officers may extend the required time frame if the party makes a written request providing a good reason for the request within the required time frame.

(7) Unless the request for reconsideration is denied as untimely filed under subsection (4)(a) of this section, the same review officer or officers who entered the final order, if reasonably available, will also consider the request as well as any responses received.

(8) The decision on the request for reconsideration must be in the form of a written order denying the request, granting the request in whole or in part and issuing a new written final order, or granting the ((~~petition~~)) request and setting the matter for further hearing.

(9) If the review officer or officers do not send an order on the request for reconsideration within twenty calendar days of the date of the notice described in subsection (4)(c) of this section, the request is deemed denied.

(10) If any party files a request for reconsideration of the final order, the reconsideration process must be completed before any judicial review may be requested. However, the filing of a ((~~petition~~)) request for reconsideration is not required before requesting judicial review.

(11) An order denying a request for reconsideration is not subject to judicial review.

(12) No evidence may be offered in support of a motion for reconsideration, except newly discovered evidence that is material for the party moving for reconsideration and that the party could not with reasonable diligence have discovered and produced prior to the final order being issued.

AMENDATORY SECTION (Amending WSR 19-01-055, filed 12/14/18, effective 1/14/19)

WAC 182-32-2140 Presiding officer—Designation and authority. The designation of a presiding officer ((~~shall~~)) must be consistent with the requirements of RCW 34.05.485 and the presiding officer ((~~shall~~)) must not have personally participated in the decision made by the school employees benefits board (SEBB) organization or SEBB program.

(1) The presiding officer will decide the issue based on the information provided by the parties during the presiding officer's review of the appeal.

(2) A presiding officer is limited to those powers granted by the state constitution, statutes, rules, or applicable case law.

(3) A presiding officer may not decide that a rule is invalid or unenforceable.

(4) In addition to the record, the presiding officer may employ the authority's expertise as a basis for the decision.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-2150 Review officer or officers—Designation and authority. (1) The designation of a review officer or officers ((~~shall~~)) must be consistent with the requirements of RCW 34.05.491 and the review officer or officers ((~~shall~~)) must not have personally participated in the decision made by the school employees benefits board (SEBB) organization or SEBB program.

(2) The review officer or officers ((~~shall~~)) must review the initial order and the record to determine if the initial order was correctly decided.

(3) The review officer or officers will issue a final order that will either:

(a) Affirm the initial order in whole or in part; or

(b) Reverse the initial order in whole or in part; or

(c) ((~~Refer~~)) Convert the matter ((~~for~~)) to a formal administrative hearing; or

(d) Remand to the presiding officer in whole or in part.

(4) A review officer or officers are limited to those powers granted by the state constitution, statutes, rules, or applicable case law.

(5) A review officer or officers may not decide that a rule is invalid or unenforceable.

(6) In addition to the record, the review officer or officers may employ the authority's expertise as a basis for the decision.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-2160 Conversion of a brief adjudicative proceeding to a formal administrative hearing. (1) The presiding officer or the review officer or officers, in their sole discretion, may convert a brief adjudicative proceeding to a formal administrative hearing at any time on motion by the subscriber or enrollee or their representative, the authority, or on the presiding officer or review officer or officers' own ((~~motion~~)).

(2) The presiding officer or review officer or officers must convert the brief adjudicative proceeding to a formal administrative hearing when it is found that the use of the brief adjudicative proceeding violates any provision of law, when the protection of the public interest requires the authority to give notice and an opportunity to participate to persons other than the parties, or when the issues and interests involved in the controversy warrant the use of the procedures of RCW 34.05.413 through 34.05.476 that govern formal administrative hearings.

(3) When a brief adjudicative proceeding is converted to a formal administrative hearing, the director designates a

hearing officer to conduct the formal administrative hearing upon notice to the subscriber or enrollee and the authority.

(4) When a brief adjudicative proceeding is converted to a formal administrative hearing, WAC 182-32-010 through 182-32-130 and WAC 182-32-3000 through 182-32-3200 apply to the formal administrative hearing.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-3000 Formal administrative hearings. (1) When a brief adjudicative proceeding is converted to a formal administrative hearing consistent with WAC 182-32-2160, the director designates a hearing officer to conduct the formal administrative hearing.

(2) Formal administrative hearings are conducted consistent with the Administrative Procedure Act, RCW 34.05.413 through 34-05-476.

(3) Part III describes the general rules and procedures that apply to school employees benefits board (SEBB) benefits formal administrative hearings.

(a) ((~~This~~)) Part III supplements the Administrative Procedure Act (APA), chapter 34.05 RCW, and the model rules of procedure in chapter 10-08 WAC. The model rules of procedure adopted by the chief administrative law judge pursuant to RCW 34.05.250, as now or hereafter amended, are hereby adopted for use by the authority in school employees benefits board (SEBB) benefits formal administrative hearings. Other procedural rules adopted in chapters 182-30, 182-31, and 182-32 WAC are supplementary to the model rules of procedure.

(b) In the case of a conflict between the model rules of procedure and ((~~this~~)) Part III, the procedural rules adopted in ((~~this~~)) Part III ((~~shall~~)) must govern.

(c) If there is a conflict between ((~~this~~)) Part III and specific SEBB program rules, the specific SEBB program rules prevail. SEBB program rules are found in chapters 182-30 and 182-31 WAC.

(d) Nothing in ((~~this~~)) Part III is intended to affect the constitutional rights of any person or to limit or change additional requirements imposed by statute or other rule. Other laws or rules determine if a hearing right exists, including the APA and program rules or laws.

AMENDATORY SECTION (Amending WSR 19-01-055, filed 12/14/18, effective 1/14/19)

WAC 182-32-3015 Hearing officers—Assignment, motions of prejudice, and disqualification. (1) **Assignment:** A hearing officer will be assigned at least five business days before a hearing. A party may ask which hearing officer is assigned to a hearing by contacting the hearing officer's office listed on the notice of hearing. If requested by a party, the hearing officer's office must send the name of the assigned hearing officer to all parties, by electronic mail or in writing, at least five business days before the scheduled hearing date.

(2) **Motion of prejudice:** Any party requesting a different hearing officer may file a written motion of prejudice against the hearing officer assigned to the matter before the hearing officer rules on a discretionary issue in the case, admits evidence, or takes testimony.

(a) A motion of prejudice must include a declaration stating that a party does not believe the hearing officer can hear the case fairly. Service of copies of the motion must also be made to all parties listed on the notice of hearing.

(b) Any party's first motion of prejudice will be automatically granted. Any subsequent motion of prejudice made by a party may be granted or denied at the discretion of the hearing officer no later than seven days after receiving the motion.

(c) A party may make an oral motion of prejudice at the beginning of a hearing before the hearing officer rules on a discretionary issue in the matter, admits evidence, or takes testimony if:

(i) The hearing officer was not assigned at least five business days before the date of the hearing; or

(ii) The hearing officer was changed within five business days of the date of the hearing.

(3) **Disqualification:** A hearing officer may be disqualified from presiding over a hearing for bias, prejudice, conflict of interest, or ex parte contact with a party to the hearing.

(a) Any party may file a petition to disqualify a hearing officer as described in RCW 34.05.425. A petition to disqualify must be in writing and service promptly made to all parties and the hearing officer upon discovering facts of possible grounds for disqualification.

(b) The hearing officer whose disqualification is requested will determine whether to grant or deny the petition in a written order, stating facts and reasons for the determination. The hearing officer must serve the order no later than seven days after receiving the petition for disqualification.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-3100 Rescheduling and continuances for formal administrative hearings. (1) Any party may request the hearing officer to reschedule a formal administrative hearing if a rule requires notice of a hearing and the amount of notice required was not provided.

(a) The hearing officer must reschedule the formal administrative hearing under circumstances identified in this chapter if requested by any party.

(b) The parties may agree to shorten the amount of notice required by any rule.

(2) Any party may request a continuance of a formal administrative hearing either orally or in writing.

(a) In each formal administrative hearing, the hearing officer must grant each party's first request for a continuance. The continuance may be up to thirty calendar days.

(b) The hearing officer may grant each party up to one additional continuance of up to thirty calendar days because of extraordinary circumstances.

(c) After granting a continuance, the hearing officer or their designee must((~~:~~

~~(i) Immediately telephone all other parties to inform them the hearing was continued; and~~

~~(ii)~~)) serve an order of continuance on the parties no later than fourteen days before the new formal administrative

hearing date. All orders of continuance must provide a new deadline for filing documents with the hearing officer. The new filing deadline can be no less than ten calendar days prior to the new formal administrative hearing date. If the continuance is granted pursuant to (b) of this subsection, then the order of continuance must also include findings of fact that state with specificity the extraordinary circumstances for which the hearing officer granted the continuance.

(3) Regardless of whether a party has been granted a continuance as described in subsection (2)(b) of this section, the hearing officer must grant a continuance if a new material issue is raised during the formal administrative hearing and a party requests a continuance.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-3120 Dispositive motions. (1) A dispositive motion could dispose of one or all the issues in a formal administrative hearing, such as a motion to dismiss or motion for summary judgment.

(2) To request a dispositive motion hearing a party must file a written dispositive motion with the hearing officer and serve a copy of the motion to all other parties. The hearing officer may also set a dispositive motion hearing, and request briefing from the parties, to address any possible dispositive issues the hearing officer believes must be addressed before the hearing.

(3) The deadline to file a timely dispositive motion ((~~shall~~)) must be ten calendar days before the scheduled hearing.

(4) Upon receiving a dispositive motion, a hearing officer:

(a) Must convert the scheduled hearing to a dispositive motion hearing when:

(i) The dispositive motion is timely filed with the hearing officer at least ten calendar days before the date of the hearing; and

(ii) The party filing the dispositive motion has not previously filed a dispositive motion.

(b) May schedule a dispositive motion hearing in all instances other than described in (a) of this subsection.

(5) The hearing officer may conduct the dispositive motion hearing in person or by telephone conference. For dispositive motion hearings scheduled to be held in person, the health care authority (HCA) hearing representative may choose to attend and participate in person or by telephone conference call.

(6) The party requesting the dispositive motion hearing must attend and participate in the dispositive motion hearing in person or by telephone. If the party requesting the motion hearing does not attend and participate in the dispositive motion hearing, the hearing officer will enter an order dismissing the dispositive motion.

(7) During a dispositive motion hearing, the hearing officer can only consider the filed dispositive motions, any response to the motions, evidence submitted to support or oppose the motions, and argument on the motions. Prior to rescheduling any necessary hearings, the hearing officer must serve a written order on the dispositive motions.

(8) The hearing officer must serve the written order on the dispositive motions to all parties no later than eighteen calendar days after the dispositive motion hearing is held. Orders on dispositive motions are subject to motions for reconsideration or petitions for judicial review as described in WAC ((~~182-32-2120 and 182-32-2130~~)) 182-32-3180 and 182-32-3200.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-3140 Orders of dismissal—Reinstating a formal administrative hearing after an order of dismissal. (1) An order of dismissal is an order from the hearing officer ending the matter. The order is entered because the party who made the appeal withdrew from the proceeding, the appellant is no longer aggrieved, the hearing officer granted a dispositive motion dismissing the matter, or the hearing officer entered an order of default because the party who made the appeal failed to attend or refused to participate in a prehearing conference or the formal administrative hearing.

(2) The order of dismissal becomes a final order if no party files a request to vacate the order as described in subsections (3) through (7) of this section.

(3) If the hearing officer enters and serves an order dismissing the formal administrative hearing, the appellant may file a written request to vacate (set aside) the order of dismissal. Upon receipt of a request to vacate an order of dismissal, the hearing officer must schedule and serve notice of a prehearing conference as described in WAC 182-32-3080. At the prehearing conference, the party asking that the order of dismissal be vacated has the burden to show good cause according to subsection (8) of this section for an order of dismissal to be vacated and the matter to be reinstated.

(4) The request to vacate an order of dismissal must be filed with the hearing officer and the other parties. The party requesting that an order of dismissal be vacated should specify in the request with good cause why the order of dismissal should be vacated.

(5) The request to vacate an order of dismissal must be filed with the hearing officer no later than twenty-one calendar days after the date the order of dismissal was entered. If no request is received within that deadline, the dismissal order becomes the health care authority's final decision without further action.

(6) If the hearing officer ((~~will consider if there is~~)) finds good cause, as described in subsection (8) of this section, for the order of dismissal to be vacated((~~.~~)), the hearing officer must enter and serve a written order to the parties setting forth the findings of fact ((~~and~~)), conclusions of law ((~~supporting the decision of whether to reinstate~~)), and the reinstatement of the matter.

(7) If the order of dismissal is vacated, the hearing officer will conduct a formal administrative hearing at which the parties may present argument and evidence about issues raised in the original appeal. The formal administrative hearing may occur immediately following the prehearing conference on the request to vacate only if agreed to by the parties

and the hearing officer, otherwise a formal administrative hearing date must be scheduled by the hearing officer.

(8) Good cause is a substantial reason or legal justification for failing to appear, act, or respond to an action using the provisions of superior court civil rule 60 as a guideline. ((~~This good cause exception applies only to this chapter.~~)) This good cause exception does not apply to any other chapter ((~~or chapters~~)) in Title 182 WAC except WAC 182-16-3140(8).

AMENDATORY SECTION (Amending WSR 19-01-055, filed 12/14/18, effective 1/14/19)

WAC 182-32-3170 Final order deadline—Required information. (1) Within ninety days after the formal administrative hearing record is closed, the hearing officer ((~~shall~~)) must serve ((~~a final order that shall be the final decision of the authority. The hearing officer shall serve~~)) a copy of the final order to all parties.

(2) ((~~The hearing officer must include the following information~~)) In the written final order, the hearing officer must:

(a) Identify the order as a final order of the school employees benefits board (SEBB) program;

(b) List the name and docket number of the case and the names of all parties and representatives;

(c) Enter findings of fact used to resolve the dispute based on the evidence admitted in the record;

(d) Explain why evidence is, or is not, credible when describing the weight given to evidence related to disputed facts;

(e) State the law that applies to the dispute;

(f) Apply the law to the facts of the case in the conclusions of law;

(g) Discuss the reasons for the decision based on the facts and the law;

(h) State the result and remedy ordered; and

(i) Include any other information required by law or program rules.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-3180 Request for reconsideration and response—Process. (1) A request for reconsideration asks the hearing officer to reconsider the final order because the party believes the hearing officer made a mistake of law, mistake of fact, or clerical error.

(2) A request for reconsideration must state in writing why the party wants the final order to be reconsidered.

(3) Requests for reconsideration must be filed with the hearing officer who entered the final order.

(4) If a party files a request for reconsideration:

(a) The hearing officer must receive the request for reconsideration on or before the tenth business day after the service date of the final order;

(b) The party filing the request must serve copies of the request on all other parties on the same day the request is served on the hearing officer; and

(c) Within five business days of receiving a request for reconsideration, the hearing officer must serve to all parties a notice that provides the date the request for reconsideration was received.

(5) The other parties may respond to the request for reconsideration. The response must state in writing why the final order should stand. Responses are optional. If a party chooses not to respond, that party will not be prejudiced because of that choice.

(a) Responses to a request for reconsideration must be received by the hearing officer no later than seven business days after the service date of the hearing officer's notice as described in subsection (4)(c) of this section, or the response will not be considered.

(b) Service of responses to a request for reconsideration must be made to all parties.

(6) If a party needs more time to file a request for reconsideration or respond to a request for reconsideration, the hearing officer may extend the required time frame if the party makes a written request providing a good reason for the request within the required time frame.

(7) No evidence may be offered in support of a motion for reconsideration, except newly discovered evidence that is material for the party moving for reconsideration and that the party could not with reasonable diligence have ((~~reasonably~~)) discovered and produced ((~~at the hearing or before the ruling on a dispositive motion~~)) prior to the final order being issued.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-3190 Decisions on requests for reconsideration. (1) Unless the request for reconsideration is denied as untimely filed under WAC 182-32-3180, the same hearing officer who entered the final order, if reasonably available, will also ((~~dispose of~~)) decide the request as well as any responses received.

(2) The decision on the request for reconsideration must be in the form of a written order denying or granting the request in whole or in part and if the request is granted issuing a new written final order.

(3) If the hearing officer does not send an order on the request for reconsideration within twenty calendar days of the date of the notice described in WAC 182-32-3180 (4)(c), the request is deemed denied.

(4) If any party files a request for reconsideration of the final order, the reconsideration process must be completed before any judicial review may be requested. However, the filing of a request for reconsideration is not required before requesting judicial review.

(5) An order denying a request for reconsideration is not subject to judicial review.

WSR 20-13-070
PROPOSED RULES
HEALTH CARE AUTHORITY
(School Employees Benefits Board)

[Admin # 2020-03—Filed June 16, 2020, 8:03 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 20-09-120.

Title of Rule and Other Identifying Information: **The following section in chapter 182-30 WAC is revised:** WAC 182-30-060 How do school employees benefits board (SEBB) organizations and contracted vendors correct enrollment errors?

Hearing Location(s): On July 21, 2020, at 10:00 a.m.

As more counties move into Phase 2 of the Governor's Safe Start plan, it is yet unknown whether by the date of this public hearing restrictions of meeting in public places will be eased. Therefore, this hearing is being held virtually only. This will not be an in-person hearing and there is not a physical location available.

You must register for this public hearing on July 21, 2020, 10:00 a.m. PDT at https://attendee.gotowebinar.com/register/6074456904428252685.

After registering, you will receive a confirmation email containing information about joining the webinar.

Date of Intended Adoption: Not sooner than July 22, 2020.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, by July 21, 2020.

Assistance for Persons with Disabilities: Contact Amber Lougheed, phone 360-725-1349, fax 360-586-9727, telecommunications relay services 711, email amber.lougheed@hca.wa.gov, by July 10, 2020.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The purpose of this proposal is to amend WAC 182-30-060 to support the SEBB program with the following:

1. To implement SEBB Policy Resolution 2020-06: If a benefits administrator or a contracted vendor provides incorrect advice regarding SEBB benefits to a school employee that they relied upon, the error will be corrected prospectively with enrollment in benefits effective the first day of the month following the date the error is identified. The health care authority (HCA) approves all error correction actions and determines if additional recourse, which may include retroactive enrollment, is warranted.

2. To make technical amendments to clarify when a SEBB organization or contracted vendor must correct enrollment errors, to clarify enrollment and termination requirements, to include premium payments and premium refund requirements, and to include recourse provisions.

Reasons Supporting Proposal: See purpose statement.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160, SEBB Policy Resolution 2020-06.

Statute Being Implemented: RCW 41.05.021, 41.05.160.

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

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Rob Parkman, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-0883; Implementation: Barbara Scott, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-0830; and Enforcement: Scott Palafox, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-1858.

A school district fiscal impact statement is not required under RCW 28A.305.135.

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

The proposed rule does not impose more-than-minor costs on businesses. Following is a summary of the agency's analysis showing how costs were calculated. These rules do not apply to small businesses.

June 16, 2020
Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-30-060 How do school employees benefits board (SEBB) organizations and contracted vendors correct enrollment errors? (~~(1) If a SEBB organization fails to provide notice of benefits eligibility or accurately enroll a school employee or their dependents in benefits, the error will be corrected prospectively with enrollment in benefits effective the first day of the month following the date the error is identified. The health care authority approves all error correction actions and determines if additional recourse, which may include retroactive enrollment, is warranted.~~

~~(2) If a SEBB organization errs and enrolls a school employee or their dependents in SEBB insurance coverage when they are not eligible and there was no fraud or intentional misrepresentation by the school employee involved, premiums and any applicable premium surcharges already paid by the school employee will be refunded by the SEBB organization to the school employee. The error will be corrected prospectively with termination of benefits effective the first day of the month following the date the error is identified.~~)) (1) A school employees benefits board (SEBB) organization or contracted vendor that makes one or more of the following enrollment errors must correct the error as described in subsections (2) through (5) of this section.

(a) Failure to timely notify a school employee of their eligibility for SEBB benefits and the employer contribution as described in WAC 182-31-030;

(b) Failure to enroll a school employee or their dependents in SEBB benefits as elected by the school employee, if the election was timely;

(c) Failure to enroll a school employee and their dependents in SEBB benefits as described in WAC 182-30-080 (1)(b);

(d) Failure to accurately reflect a school employee's premium surcharge attestation on the school employee's account;

(e) Enrolling a school employee or their dependents in SEBB insurance coverage when they are not eligible as described in WAC 182-31-040 or 182-31-140 and it is clear there was no fraud or intentional misrepresentation by the school employee involved; or

(f) Providing incorrect information, via a benefits administrator or contracted vendor, regarding SEBB benefits to the employee that they relied upon.

(2) The SEBB organization or the applicable contracted vendor must enroll the school employee and the school employee's dependents, as elected, or terminate enrollment in SEBB benefits as described in subsection (3) of this section, reconcile premium payments and applicable premium surcharges as described in subsection (4) of this section, and provide recourse as described in subsection (5) of this section.

(3) **Enrollment or termination.**

(a) SEBB medical, vision, and dental enrollment is effective at a minimum the first day of the month following the date the enrollment error is identified, unless the authority determines additional recourse is warranted, as described in subsection (5) of this section;

(b) Basic life, basic accidental death and dismemberment (AD&D), and basic long-term disability (LTD) insurance enrollment is retroactive to the first day of the month following the day the school employee became newly eligible, or the first day of the month the school employee regained eligibility, as described in WAC 182-30-080;

(c) Supplemental life, supplemental AD&D, and supplemental LTD insurance enrollment is retroactive to the first day of the month following the day the school employee became newly eligible if the school employee elects to enroll in this coverage (or if previously elected, the first of the month following the signature date on the school employee's application for this coverage). If a SEBB organization enrollment error occurred when the school employee regained eligibility for the employer contribution following a period of leave as described in WAC 182-30-080(3).

(i) Supplemental life and supplemental AD&D is enrolled the first day of the month the school employee regained eligibility, at the same level of coverage the school employee continued during the period of leave, without evidence of insurability.

(ii) If the school employee was eligible to continue supplemental life insurance and supplemental AD&D insurance during the period of leave but did not, the school employee must provide evidence of insurability and receive approval from the contracted vendor.

(iii) School employees may not continue supplemental LTD insurance while on leave without pay as described in WAC 182-31-100. Supplemental LTD insurance is reinstated the first day of the month the employee regains eligibility, to the level of coverage the employee was enrolled in prior to the period of leave, without evidence of insurability.

(d) If the school employee is eligible and elects (or elected) to enroll in the medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP), enrollment is limited to three months prior to the date enrollment is processed, but not earlier than the current plan year. If a school employee was not enrolled in a medical FSA or DCAP as elected, the school employee may either participate at the amount originally elected with a corresponding increase in contributions for the balance of the plan year, or participate at a reduced amount for the plan year by maintaining the per-pay period contribution in effect;

(e) If the school employee or their dependent was not eligible but still enrolled as described in subsection (1)(e) of this section, the employee's or their dependent's SEBB benefits will be terminated prospectively effective as of the last day of the month.

(4) **Premium payments.**

(a) The SEBB organization must remit to the authority the employer contribution and the school employee contribution for health plan premiums, applicable premium surcharges, basic life, basic AD&D, and basic LTD starting the date SEBB benefits begin as described in subsections (3) and (5)(a)(i) of this section. If a SEBB organization failed to notify a newly eligible school employee of their eligibility for SEBB benefits, the SEBB organization may only collect the school employee contribution for health plan premiums and applicable premium surcharges for coverage for the months after the school employee was notified.

(b) When a SEBB organization fails to correctly enroll the amount of supplemental LTD insurance elected by the school employee, premiums will be corrected as follows:

(i) When additional premiums are due to the authority, the school employee is responsible for premiums for the most recent twenty-four months of coverage. The SEBB organization is responsible for additional months of premiums; and

(ii) When a premium refund is due to the school employee, the supplemental LTD insurance contracted vendor is responsible for premium refunds for the most recent twenty-four months of coverage. The SEBB organization is responsible for additional months of premium refunds after the twenty-four months of coverage and the overall refunding process to the school employee.

(c) When a SEBB organization mistakenly enrolls a school employee or their dependents as described in subsection (1)(e) of this section, premiums and any applicable premium surcharges will be refunded by the SEBB organization to the school employee without rescinding the insurance coverage.

(5) **Recourse.**

(a) School employee eligibility for SEBB benefits begins on the first day of the month following the date eligibility is established as described in WAC 182-31-040. Dependent eligibility is described in WAC 182-31-140, and dependent enrollment is described in WAC 182-31-150. When retroactive correction of an enrollment error is limited as described in subsection (3)(b), (c), and (d) of this section, the SEBB organization must work with the school employee, and receive approval from the authority, to implement retroactive SEBB benefits within the following parameters:

(i) Retroactive enrollment in a SEBB insurance coverage;

(ii) Reimbursement of claims paid;

(iii) Reimbursement of amounts paid by the school employee or dependent for medical, vision, and dental premiums;

(iv) Reimbursement of amounts paid by the school employee for the premium surcharges;

(v) Other legal remedy received or offered; or

(vi) Other recourse, upon approval by the authority.

(b) Recourse must not contradict a specific provision of federal law or statute and does not apply to requests for noncovered services or in the case of an individual who is not eligible for SEBB benefits.

WSR 20-13-071
PROPOSED RULES
HEALTH CARE AUTHORITY
(School Employees Benefits Board)
[Admin # 2020-02—Filed June 16, 2020, 8:05 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 20-09-121.

Title of Rule and Other Identifying Information: WAC 182-30-130 What are the requirements for a school employees benefits board (SEBB) organization engaging in local negotiations regarding SEBB benefits eligibility criteria?

Hearing Location(s): On July 21, 2020, at 10:00 a.m.

As more counties move into Phase 2 of the Governor's Safe Start plan, it is yet unknown whether by the date of this public hearing restrictions of meeting in public places will be eased. Therefore, this hearing is being held virtually only. This will not be an in-person hearing and there is not a physical location available.

You must register for this public hearing on July 21, 2020, 10:00 a.m. PDT at https://attendee.gotowebinar.com/register/6074456904428252685. After registering, you will receive a confirmation email containing information about joining the webinar.

Date of Intended Adoption: Not sooner than July 22, 2020.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, by July 21, 2020.

Assistance for Persons with Disabilities: Contact Amber Lougheed, phone 360-725-1349, fax 360-586-9727, telecommunications relay services 711, email amber.lougheed@hca.wa.gov, by July 10, 2020.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The purpose of this proposal is to amend WAC 182-30-130 to support the school employees benefits board (PEBB) program.

Implement school employees benefits board (SEBB) policy resolutions and making technical amendments: Amended WAC 182-30-130 to clarify that a SEBB organization, engaging in local negotiations regarding SEBB benefits eligibility criteria, must establish a threshold of anticipated work hours no less than one hundred eighty hours but less than the minimum hours to meet SEBB eligibility under WAC 182-31-040 within a school year.

Reasons Supporting Proposal: See purpose statement.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160, and SEBB Policy Resolutions 2020-04.

Statute Being Implemented: RCW 41.05.021, 41.05.160.

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

Name of Proponent: Health care authority (HCA), governmental.

Name of Agency Personnel Responsible for Drafting: Rob Parkman, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-0883; Implementation: Barbara Scott, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-0830; and Enforcement: Scott Palafox, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-1858.

A school district fiscal impact statement is not required under RCW 28A.305.135.

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

The proposed rule does not impose more-than-minor costs on businesses. Following is a summary of the agency's analysis showing how costs were calculated. These rules do not apply to small businesses.

June 16, 2020
Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-30-130 What are the requirements for a school employees benefits board (SEBB) organization engaging in local negotiations regarding SEBB benefits eligibility criteria? This section describes the terms and conditions for a school employees benefits board (SEBB) organization that is engaging in local negotiations regarding eligibility for school employees as described in RCW 41.05.740 (6)(e).

(1) A SEBB organization must provide a current ratified collective bargaining agreement (CBA) and information on all eligible school employees under the CBA to the health care authority (HCA) by the start of the school year.

(2) A SEBB organization must offer all of, and only, the following SEBB benefits to employees and their dependents:

(a) Medical (includes the wellness incentive);

(b) Dental;

(c) Vision;

(d) Basic life;

(e) Basic accidental death and dismemberment (AD&D) insurance.

(3) A SEBB organization must provide an employer contribution as described below:

(a) The subscriber-only employer medical contribution (EMC) amount for school employees eligible under RCW 41.05.740 (6)(d) multiplied by the premium tier ratio associated with the enrollment tier selected by the school employee;

(b) One hundred percent of the cost for the school employee dental plan multiplied by the enrollment tier selected by the school employee;

(c) One hundred percent of the cost for the school employee vision plan multiplied by the enrollment tier selected by the school employee;

(d) One hundred percent of the cost for basic life and accidental death and dismemberment (AD&D) insurance;

(e) One hundred percent of the cost of the administrative fee charged by the HCA; and

(f) One hundred percent of the monthly K-12 remittance for deposit in the retired school employees' subsidy account.

(4) A SEBB organization providing SEBB benefits as described in this section may do so by group as described in (a) through (d) of this subsection:

(a) The entire SEBB organization;

(b) A entire collective bargaining unit;

(c) A group containing all nonrepresented school employees; or

(d) A combination of (b) and (c) of this subsection.

(5) A SEBB organization must establish a threshold of anticipated work hours no less than one hundred eighty hours ((~~and no more~~)) but less than the minimum hours to meet SEBB eligibility under WAC 182-31-040 within a school year.

(6) All of the rules in chapters 182-30, 182-31, and 182-32 WAC apply, except for all rules governing SEBB benefits that are not available to school employees whose eligibility is established under this section. The following benefits are not available to school employees whose eligibility is established under this section:

(a) Long-term disability (LTD);

(b) Medical flexible spending arrangement (FSA);

(c) Dependent care assistance program (DCAP); and

(d) Supplemental life insurance.

(7) If a school employee waives medical under this section, there is no requirement to send the employer contribution to the HCA as required in WAC 182-30-070(4).

(8) Eligibility determinations must align with the SEBB program's status as a governmental plan under Section 3(32) of the Employee Retirement Income Security Act of 1974 (ERISA) as amended. This means the SEBB organization may only consider school employees whose services are substantially all in the performance of essential governmental functions, but not in the performance of commercial activities, whether or not those activities qualify as essential governmental functions to be eligible.

(9) A SEBB organization providing SEBB benefits to a group of school employees under this section must notify the SEBB program each time the CBA is renegotiated.

WSR 20-13-072
PROPOSED RULES
HEALTH CARE AUTHORITY
(School Employees Benefits Board)

[Admin # 2020-01—Filed June 16, 2020, 8:07 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 20-09-122.

Title of Rule and Other Identifying Information: WAC 182-31-040 How do school employees establish eligibility for the employer contribution toward SEBB benefits and when do SEBB benefits coverage begin?

Hearing Location(s): On July 21, 2020, at 10:00 a.m.

As more counties move into Phase 2 of the Governor's Safe Start plan, it is yet unknown whether by the date of this public hearing restrictions of meeting in public places will be eased. Therefore, this hearing is being held virtually only. This will not be an in-person hearing and there is not a physical location available.

You must register for this public hearing on July 21, 2020, 10:00 a.m. PDT at https://attendee.gotowebinar.com/register/6074456904428252685. After registering, you will receive a confirmation email containing information about joining the webinar.

Date of Intended Adoption: Not sooner than July 22, 2020.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, by July 21, 2020.

Assistance for Persons with Disabilities: Contact Amber Lougheed, phone 360-725-1349, fax 360-586-9727, telecommunications relay services 711, email amber.lougheed@hca.wa.gov, by July 10, 2020.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The purpose of this proposal is to amend WAC 182-31-040 to support the school employees benefits board (SEBB) program.

Implement SEBB policy resolutions and make technical amendments: Amended WAC 182-31-040 to make technical corrections for readability and update references as needed for structural changes. Amended subsection (3) to include all hours that a school employee receives compensation from their SEBB organization for a paid holiday or while on approved leave to the hours that count while determining eligibility for SEBB program benefits. Amended subsection (6) to add a new method for a school employee who returns from an approved leave without pay to maintain or establish eligibility. Amended subsection (7) to clarify what benefits are available and the date that they will begin and to add an exception to when benefits are earned in the month of August.

Reasons Supporting Proposal: See purpose statement.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160, SEBB Policy Resolutions 2020-01, 2020-02, and 2020-05.

Statute Being Implemented: RCW 41.05.021, 41.05.160.

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

Name of Proponent: Health care authority (HCA), governmental.

Name of Agency Personnel Responsible for Drafting: Rob Parkman, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-0883; Implementation: Barbara Scott, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-0830; and Enforcement: Scott Palafox, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-1858.

A school district fiscal impact statement is not required under RCW 28A.305.135.

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

The proposed rule does not impose more-than-minor costs on businesses. Following is a summary of the agency's analysis showing how costs were calculated. These rules do not apply to small businesses.

June 16, 2020
Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-31-040 How do school employees establish eligibility for the employer contribution toward school employees benefits board (SEBB) benefits and when do SEBB benefits ((~~coverage~~)) begin? (1) Eligibility shall be determined solely by the criteria that most closely describes the school employee's work circumstance.

(2) School employee eligibility criteria:

(a) A school employee is eligible for the employer contribution toward((~~s~~)) school employees benefits board (SEBB) benefits if they are anticipated to work at least six hundred thirty hours per school year. The eligibility effective date for a school employee eligible under this subsection shall be determined as follows:

(i) If the school employee's first day of work is on or after September 1st but not later than the first day of school for the current school year as established by the SEBB organization, they are eligible for the employer contribution on the first day of work; or

(ii) If the school employee's first day of work is at any other time during the school year, they are eligible for the employer contribution on that day.

(b) A school employee who is not anticipated to work at least six hundred thirty hours in the school year becomes eligible for the employer contribution toward((~~s~~)) SEBB benefits on the date their work pattern is revised in such a way that they are now anticipated to work six hundred thirty hours in the school year.

(c) A school employee who is not anticipated to work at least six hundred thirty hours in the school year becomes eligible for the employer contribution toward((~~s~~)) SEBB benefits on the date they actually worked six hundred thirty hours in the school year.

(d) A school employee who is not anticipated to work six hundred thirty hours within the school year because of the time of year they are hired but is anticipated to work at least six hundred thirty hours the next school year, establishes eligibility for the employer contribution toward SEBB benefits as of their first working day if they are:

(i) A nine to ten month school employee anticipated to be compensated for at least seventeen and one-half hours a week in six of the last eight weeks counting backwards from the week that contains the last day of school; or

(ii) A twelve month school employee anticipated to be compensated for at least seventeen and one-half hours a week in six of the last eight weeks counting backwards from the week that contains August 31st, the last day of the school year.

(3) All hours worked by an employee in their capacity as a school employee must be included in the calculation of hours for determining eligibility. All hours for which a school employee receives compensation from a SEBB organization during an approved leave (e.g., sick leave, personal leave, bereavement leave) or a paid holiday must be included when determining how many hours a school employee is anticipated to work, or did work, in the school year.

(4) A school employee may establish eligibility for the employer contribution toward SEBB benefits by stacking of hours from multiple positions within one SEBB organization. A school employee may not gain eligibility by stacking of hours from multiple SEBB organizations.

(5) A school employee is presumed eligible for the employer contribution at the start of the school year, as described in subsection (2)(a) of this section, if they:

(a) Worked at least six hundred thirty hours in each of previous two school years; and

(b) Are returning to the same type of position (teacher, paraeducator, food service worker, custodian, etc.) or combination of positions with the same SEBB organization.

Note: A SEBB organization rebuts this presumption by notifying the school employee, in writing, of the specific reasons why the school employee is not anticipated to work at least six hundred thirty hours in the current school year and how to appeal the eligibility determination.

(6) A school employee who returns from approved leave without pay will maintain or establish eligibility for the employer contribution toward SEBB benefits if their work schedule, had it been in effect at the start of the school year, would have resulted in the school employee being anticipated to work the minimum hours to meet SEBB eligibility for the employer contribution in the school year. A school employee who regains eligibility under this subsection establishes eligibility for the employer contribution toward SEBB benefits as of the date they returned from approved leave without pay.

(7) When SEBB benefits begin:

(a) For a school employee who establishes eligibility under subsection (2)(a)(i) of this section ((~~SEBB benefits~~)), medical, dental, vision, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, basic long-term disability (LTD) insurance, and if eligible, benefits under the salary reduction plan begin on the first day of work for the new school year. Supplemental life insurance, supplemental AD&D insurance, and supplemental LTD insurance begin on the first day of the month following the date the contracted vendor receives the required form or approves the enrollment.

(b) For a school employee who establishes eligibility under subsection (2)(a)(ii), (b), (c), ((~~or~~)) (d), or (6) of this section, ((~~SEBB insurance coverage~~)) medical, dental, vision, basic life insurance, basic AD&D insurance, basic LTD insurance, and if eligible, benefits under the salary reduction plan begin((~~s~~)) on the first day of the month following the date the school employee becomes eligible for the employer contribution toward((~~s~~)) SEBB benefits. Supplemental life insurance, supplemental AD&D insurance, and supplemental LTD insurance begin on the first day of the month following the date the contracted vendor receives the required form or approves the enrollment.

Exception: When a school employee establishes eligibility for the employer contribution toward SEBB benefits as described under subsection (2)(b) or (c), or (6) of this section, at any time in the month of August, SEBB benefits begin on September 1st only if the school employee is also determined to be eligible for the employer contribution toward SEBB benefits for the school year that begins on September 1st.

((~~(7)~~)) (8) If the school employee is not eligible under subsections (1) through ((~~(5)~~)) (6) of this section, they may be eligible for SEBB benefits if their SEBB organization is

engaging in local negotiations regarding eligibility for school employees as described in WAC 182-30-130.

WSR 20-13-073
PROPOSED RULES
HEALTH CARE AUTHORITY
(Public Employees Benefits Board)

[Admin # 2020-03—Filed June 16, 2020, 8:09 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 20-09-116.

Title of Rule and Other Identifying Information: **The following sections in chapter 182-08 WAC are revised:** WAC 182-08-015 Definitions, 182-08-180 Premium payments and premium refunds, 182-08-185 What are the requirements regarding premium surcharges?, 182-08-187 How do employing agencies and contracted vendors correct enrollment errors and is there a limit on retroactive enrollment?, 182-08-190 The employer contribution is set by the health care authority (HCA) and paid to the HCA for all eligible employees, 182-08-191 Subscriber address requirements, 182-08-196 What happens if my health plan becomes unavailable due to a change in contracted service area or eligibility for medicare?, 182-08-198 When may a subscriber change health plans?, 182-08-199 When may an employee enroll, or revoke an election and make a new election under the premium payment plan, medical flexible spending arrangement (FSA), or dependent care assistance program (DCAP)?, 182-08-235 Employer group and board of directors for school districts and educational service districts application process, and 182-08-245 Employer group and board members of school districts and educational service districts participation requirements.

The following sections in chapter 182-12 WAC are revised: WAC 182-12-109 Definitions, 182-12-111 Which entities and individuals are eligible for public employees benefits board (PEBB) benefits?, 182-12-113 What are the obligations of a state agency in the application of employee eligibility?, 182-12-114 How do employees establish eligibility for public employees benefits board (PEBB) benefits?, 182-12-123 Is dual enrollment in public employees benefits board (PEBB) prohibited?, 182-12-128 When may an employee waive enrollment in public employees benefits board (PEBB) medical and when may they enroll in PEBB medical after having waived enrollment?, 182-12-129 What happens when an employee moves from an eligible to an otherwise ineligible position or job due to a layoff?, 182-12-131 How do eligible employees maintain the employer contribution toward public employees benefits board (PEBB) benefits?, 182-12-133 What options for continuation coverage are available to employees and their dependents during certain types of leave or when employment ends due to a layoff?, 182-12-138 What options are available if an employee is approved for the federal Family and Medical Leave Act (FMLA) or the paid family and medical leave program?, 182-12-141 If an employee reverts from an eligible position, what happens to their public employees benefits board (PEBB) insurance coverage?, 182-12-142 What options for continuation coverage are available to faculty and seasonal employees who are between periods of eligibility?, 182-12-146 When is an enrollee eligible to continue public employees benefits board (PEBB) benefits under Consolidated Omnibus Budget Reconciliation Act (COBRA)?, 182-12-148 What options for continuation coverage are available to employees during their appeal of dismissal?, 182-12-207 When can a retiree or an eligible dependent's public employees benefits board (PEBB) insurance coverage be terminated by the health care authority (HCA)?, 182-12-208 What are the requirements regarding enrollment in dental under public employees benefits board (PEBB) retiree insurance coverage?, 182-12-209 Who is eligible for retiree term life insurance?, 182-12-250 Public employees benefits board (PEBB) insurance coverage eligibility for survivors of emergency service personnel killed in the line of duty, 182-12-260 Who are eligible dependents?, 182-12-262 When may subscribers enroll or remove eligible dependents?, 182-12-263 National Medical Support Notice (NMSN), 182-12-270 What options for continuation coverage are available to dependents who cease to meet the eligibility criteria as described in WAC 182-12-260?, and 182-12-300 Public employees benefits board (PEBB) wellness incentive program eligibility and procedural requirements.

The following sections in chapter 182-16 WAC are revised: WAC 182-16-020 Definitions, 182-16-058 Service or serve, 182-16-066 Burden of proof, standard of proof, and presumptions, 182-16-120 Computation of time, 182-16-130 Index of significant decisions, 182-16-2010 Appealing a decision regarding public employees benefits board (PEBB) eligibility, enrollment, premium payments, premium surcharges, a wellness incentive, or the administration of benefits, 182-16-2020 Appealing a decision made by a state agency about eligibility, premium surcharges, or enrollment in benefits, 182-16-2030 Appealing a public employees benefits board (PEBB) program decision regarding eligibility, enrollment, premium payments, premium surcharges, a PEBB wellness incentive, or certain decisions made by an employer group, 182-16-2040 How can a subscriber appeal a decision regarding the administration of wellness incentive program requirements?, 182-16-2050 How can an employee appeal a decision regarding the administration of benefits offered under the salary reduction plan?, 182-16-2060 How can an entity or organization appeal a decision of the health care authority to deny an employer group application?, 182-16-2070 What should a written request for administrative review and a request for brief adjudicative proceeding contain?, 182-16-2085 Continuances, 182-16-2090 Initial order, 182-16-2100 How to request a review of an initial order resulting from a brief adjudicative proceeding, 182-16-2110 Final order, 182-16-2120 Request for reconsideration, 182-16-2150 Review officer or officers—Designation and authority, 182-16-2160 Conversion of a brief adjudicative proceeding to a formal administrative hearing, 182-16-3000 Formal administrative hearings, 182-16-3030 Authority of the hearing officer, 182-16-3100 Rescheduling and continuances for formal administrative hearings, 182-16-3120 Dispositive motions, 182-16-3130 Subpoenas, 182-16-3140 Orders of dismissal—Reinstating a formal administrative hearing after an order of dismissal, 182-16-3170 Final order deadline—

Required information, 182-16-3180 Request for reconsideration and response—Process, and 182-16-3190 Decisions on requests for reconsideration.

Hearing Location(s): On July 21, 2020, at 10:00 a.m.

As more counties move into Phase 2 of the Governor's Safe Start plan, it is yet unknown whether by the date of this public hearing restrictions of meeting in public places will be eased. Therefore, this hearing is being held virtually only. This will not be an in-person hearing and there is not a physical location available.

You must register for this public hearing on July 21, 2020, 10:00 a.m. PDT at https://attendee.gotowebinar.com/register/6074456904428252685.

After registering, you will receive a confirmation email containing information about joining the webinar.

Date of Intended Adoption: Not sooner than July 22, 2020.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, by July 21, 2020.

Assistance for Persons with Disabilities: Contact Amber Lougheed, phone 360-725-1349, fax 360-586-9727, telecommunications relay services 711, email amber.lougheed@hca.wa.gov, by July 10, 2020.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The purpose of this proposal is to amend some of the existing rules to support the public employees benefits board (PEBB) program.

1. Make Technical Amendments:

- Within the definitions sections of chapters 182-08, 182-12, and 182-16 WAC:
  - Amended the definition of "Calendar days" or "Days" to align with statute;
  - Made technical amendments to the definition "Health plan" by clarifying the board approves the health plan;
  - Amended the definition of "PEBB program" by adding a reference for eligible retired employees.
- Within the definitions sections of chapters 182-08 and 182-12 WAC:
  - Amended the definition of "Continuation coverage" to allow continuation of PEBB benefits instead of health plan coverage;
  - Amended the definition of "Defer" to allow deferral of PEBB insurance coverage instead of only health plans;
  - Amended the definition of "Waive" to clarify that only medical coverage may be waived;
- Within the definitions section of chapter 182-12 WAC:
  - Made a technical amendment to the definition of "Accidental death and dismemberment insurance";
  - Amended the definition of "SEBB" to remove the reference to the board;
  - Amended the definition of "SEBB insurance coverage" to include medical, dental, and vision coverage;
- Within the definitions section of chapter 182-16 WAC:
  - Added a definition of "Board".
  - Amended the definition of "Business days" to specify state legal holidays.
- Made global amendments in chapters 182-08, 182-12, and 182-16 WAC to update the use of health plan, PEBB insurance coverage, PEBB benefits, and specific benefits.
- Amended WAC 182-08-180 to clarify premium payments may be made to the contracted vendor in addition to the Health Care Authority (HCA). Clarified notification regarding delinquent monthly premiums for a medicare advantage or medicare advantage-prescription drug plan. Amended WAC 182-08-180 to no longer allow insurance coverage to be terminated for non-payment when an employee is on FMLA.
- Amended WAC 182-08-185 to update internal references and clarified that the spousal surcharge is based on enrollment in PEBB medical coverage.
- Amended WAC 182-08-187 to clarify that errors are related to PEBB benefits enrollment instead of insurance enrollment, updated vendors to the defined term contracted vendor. Clarified that refunds could be part of recourse. Also updated internal references, removed a note regarding notice requirements, added a WAC reference regarding supplemental LTD insurance during the period of leave, and made minor changes for readability.
- Amended WAC 182-08-187 and 182-12-113 because of the requirement for employees [to] be given at least ten days to make elections.
- Amended WAC 182-08-190 to clarify that the employer contribution goes towards PEBB benefits and includes enrolled dependents.
- Amended WAC 182-08-191 to provide technical corrections about addressing updates for appellants.
- Amended WAC 182-08-196 to reference high deductible health plans instead of consumer directed health plans and added clarity about timelines for electing a new medicare advantage plan.
- Amended WAC 182-08-198 to clarify that gaining initial eligibility or regaining eligibility does not create a special open enrollment. Added language about medicare advantage or medicare advantage-prescription drug plans. Clarified health plans start dates for extended and disabled dependents. Added clarity about changing medical plans when the subscriber is not eligible for a health savings account and that subscribers may not change their medical plan if it conflicts with the cafeteria plan.
- Amended WAC 182-08-198, 182-08-199, 182-12-128, and 182-12-250 from entitlement to enrollment in medicare, medicaid, or children's health insurance program (CHIP).
- Amended WAC 182-08-235, 182-08-245, 182-12-111, and 182-12-146 to allow school board members to contract with the PEBB program for PEBB insurance coverage, and to outline the eligibility, procedural requirements, and continuation coverage options available.
- Amended WAC 182-08-245 to update information regarding employer groups or board members of school districts and educational service districts must submit to the PEBB program.

- Amended WAC 182-12-111 to board members of Washington state school districts and educational service districts eligibility and application process.
- Amended WAC 182-12-114 to clarify how governor declared emergencies impact eligibility. Added information about when benefits under the salary reduction plan, supplemental LTD, supplemental AD&D, and supplemental life begin.
- Amended WAC 182-12-123 to clarify employees may only have one enrollment in medical and dental. Amended WAC 182-12-123 and 182-12-250 to update the term "PEBB health plan" to "PEBB retiree insurance coverage" when speaking about deferring.
- Amended WAC 182-12-128 to clarify when medical coverage will begin for the newly born child, provide clarification on returning from waive status following medicaid or CHIP, newly adopted child, spouse, or state registered domestic partner and make minor technical corrections.
- Amended WAC 182-12-133 and 182-12-142 to clarify continuation coverage options for life and AD&D insurance.
- Amended WAC 182-12-138 to clarify and add details about the Paid Family and Medical Leave Program (PFML) and removed language to no longer allow insurance coverage to be terminated for non-payment when an employee is on FMLA or PFML.
- Amended WAC 182-12-146 to clarify, add details, and update references [to] clarify that state registered domestic partners and their children and a board member may have COBRA coverage on the same terms as a spouse or other eligible dependents.
- Amended WAC 182-12-148 to add "court: as an entity to review a dismissal action, specify coverage "terminates" rather than "ends", and specifying employees "may enroll in" supplemental coverage rather than having coverage "restored" if retroactive premiums are not received.
- Amended WAC 182-12-207 to provide clarity that PEBB retiree insurance can be terminated for misconduct.
- Amended WAC 182-12-209 to clarify the retiree term life enrollment and deferral process.
- Amended WAC 182-12-250 to clarify medicare eligibility, added more information about enrollment in medicare advantage or medicare advantage-prescription drug plans and clarified enrollment requirements for those who are eligible for medicare Parts A and B.
- Amended WAC 182-12-260 to specify that dependent verification applies to PEBB health plan enrollment, clarified dependent verification for a dependent child with a disability beginning at age twenty-six, removed parents as an eligible dependent, added clarification regarding a dependent child with a disability process and clarified when dependents may be added.
- Amended WAC 182-12-262 to clarify when PEBB insurance coverage begins including supplemental dependent life and AD&D insurance, that a National Medical Support Notice allows a subscriber to add or remove dependents, and that supplemental dependent life and AD&D insurance may be elected or removed anytime. Clarified enrollment requirements regarding supplemental dependent life and AD&D insurance. Added information about medicare advantage clarify premiums and applicable premium surcharges payments and to and medicare advantage-prescription drug plans.
- Amended WAC 182-12-263 to clarify when a dependent already enrolled may be removed from health plan coverage.
- Amended WAC 182-12-270 to specify that that [the] medical and dental premiums and applicable premium surcharges must be made to HCA and premium surcharges are related to medical coverage and that state registered domestic partners and their children may have COBRA on the same terms as a spouse or other eligible dependents.
- Amended WAC 182-12-300 to clarify that you must be enrolled in a PEBB medical plan to receive the wellness incentive and made minor technical corrections.
- Amended WAC 182-16-058 with technical corrections.
- Amended WAC 182-16-066 to refer to "state agencies."
- Amended WAC 182-16-120 to make technical changes including specifying state legal holidays.
- Amended WAC 182-16-130 to specify orders instead of decisions.
- Amended WAC 182-16-2010 to correct the name of the salary reduction plan.
- Amended WAC 182-16-2020 to specify that requests for administrative review must be written and provided deadlines for PEBB appeals unit to receive requests for administrative review. Changes clarify what happens if an employee does not appeal a brief adjudicative proceeding.
- Amended WAC 182-16-2030 for readability.
- Amended WAC 182-16-2040 clarify the decision if a subscriber fails to request a brief adjudicative proceeding timely.
- Amended WAC 182-16-2050 to specify that request for review must be a written request, added language about requesting a brief adjudicative proceeding, and information about [when] orders are effective, and changed the word to decision order.
- Amended WAC 182-16-2060 to clarify the decision if a brief adjudicative proceeding is not requested timely.
- Amended WAC 182-16-2070 to specify review of employing agency decisions.
- Amended WAC 182-16-2085 and 182-16-2160 to remove the word "motion" for readability.
- Amended WAC 182-16-2090 to spell out PEBB and to make other changes for reability [readability].
- Amended WAC 182-16-2100 to specify that the initial order becomes the authority's final order and changes for readability.
- Amended WAC 182-16-2110 to make technical corrections.
- Amended WAC 182-16-2110, 182-16-2150, and 182-16-3170 by streamlining language to improve readability.
- Amended WAC 182-16-2120 updated a reference and changes for readability.

- Amended WAC 182-16-3000 and 182-16-3120 by updating references.
- Amended WAC 182-16-3030 may allow argument only to preserve the record for judicial review.
- Amended WAC 182-16-3100 to specify rescheduling the formal administrative hearing and removed the requirement to immediately telephone all other parties in the event of a continuance.
- Amended WAC 182-16-3130 to spell out HCA the first time it is used.
- Amended WAC 182-16-3140 to update "good cause" requirements, update references, and make a minor change for readability.
- Amended WAC 182-16-3180 clarified what new information may be introduced.
- Amended WAC 182-16-3190 by replacing "dispose of" with "decide."

2. Amend rules to improve administration of the PEBB program:

- Amended WAC 182-08-180 to add the acronym AD&D after the accidental death and dismemberment insurance.
- Amended WAC 182-08-190 to remove repetitive language.
- Amended WAC 182-08-199 by making corrections to use the correct acronyms.
- Amended WAC 182-12-111 by making corrections to the format and using the correct acronyms.

Reasons Supporting Proposal: See purpose statement.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Statute Being Implemented: RCW 41.05.021, 41.05.160.

Rule is necessary because of federal law, Title 42 C.F.R., 42 C.F.R. § 422.62(b) and 423.38(c).

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Rob Parkman, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-0883; Implementation: Barbara Scott, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-0830; and Enforcement: Scott Palafox, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-1858.

A school district fiscal impact statement is not required under RCW 28A.305.135.

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

The proposed rule does not impose more-than-minor costs on businesses. Following is a summary of the agency's analysis showing how costs were calculated. These rules do not apply to small businesses.

June 16, 2020
Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

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

"Accidental death and dismemberment insurance" or "AD&D" means basic accidental death and dismemberment (AD&D) insurance paid for by the employing agency, as well as supplemental accidental death and dismemberment insurance offered to and paid for by employees for themselves and their dependents.

"Affordable Care Act" means the federal Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, P.L. 111-152, or federal regulations or guidance issued under the Affordable Care Act.

"Annual open enrollment" means an annual event set aside for a period of time by the HCA when subscribers may make changes to their health plan enrollment and salary reduction elections for the following plan year. During the annual open enrollment, subscribers may transfer from one health plan to another, enroll or remove dependents from coverage, enroll in coverage, or waive enrollment in PEBB medical. Employees eligible to participate in the salary reduction plan may enroll in or change their election under the dependent care assistance program (DCAP) or the medical flexible spending arrangement (FSA). They may also enroll in or opt out of the premium payment plan.

"Authority" or "HCA" means the Washington state health care authority.

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

"Calendar days" or "days" means all days including Saturdays, Sundays, and all ((~~legal~~)) state legal holidays as set forth in RCW 1.16.050.

"Consolidated Omnibus Budget Reconciliation Act" or "COBRA" means continuation coverage as administered under 42 U.S.C. Secs. 300bb-1 through 300bb-8.

"Continuation coverage" means the temporary continuation of ((~~health plan coverage~~)) PEBB benefits available to enrollees under the Consolidated Omnibus Budget Reconciliation Act (COBRA), 42 U.S.C. Secs. 300bb-1 through 300bb-8, the Uniformed Services Employment and Reemployment Rights Act (USERRA), 38 U.S.C. Secs. 4301 through 4335, or the public employees benefits board's policies.

"Contracted vendor" means any person, persons, or entity under contract or agreement with the HCA to provide goods or services for the provision or administration of PEBB benefits. The term "contracted vendor" includes subcontractors of the HCA and subcontractors of any person, persons, or entity under contract or agreement with the HCA that provide goods or services for the provision or administration of PEBB benefits.

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

"Defer" means to postpone enrollment or interrupt enrollment in ((~~a~~)) PEBB ((~~health plan~~)) insurance coverage by a retiree or an eligible survivor.

"Dependent" means a person who meets eligibility requirements in WAC 182-12-260, except that "surviving spouses, state registered domestic partners, and dependent children" of emergency service personnel who are killed in the line of duty is defined in WAC 182-12-250.

"Dependent care assistance program" or "DCAP" means a benefit plan whereby employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan under chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 129 or other sections of the Internal Revenue Code.

"Director" means the director of the authority.

"Documents" means papers, letters, writings, electronic mail, electronic files, or other printed or written items.

"Employee" for the public employees benefits board program includes all employees of the state, whether or not covered by civil service; elected and appointed officials of the executive branch of government, including full-time members of boards, commissions, or committees; justices of the supreme court and judges of the court of appeals and the superior courts; and members of the state legislature. Pursuant to contractual agreement with the authority, "employee" may also include: (a) Employees of a county, municipality, or other political subdivision of the state and members of the legislative authority of any county, city, or town who are elected to office after February 20, 1970, if the legislative authority of the county, municipality, or other political subdivision of the state submits application materials to the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.04.205 and 41.05.021 (1)(g); (b) employees of employee organizations representing state civil service employees, at the option of each such employee organization; (c) through December 31, 2019, employees of a school district or represented employees of an educational service district if the authority agrees to provide any of the school districts' or educational service districts' insurance programs by contract with the authority as provided in RCW 28A.400.350; (d) employees of a tribal government, if the governing body of the tribal government seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(f) and (g); (e) employees of the Washington health benefit exchange if the governing board of the exchange established in RCW 43.71.020 seeks and receives approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(g) and (n); (f) through December 31, 2019, employees of a charter school established under chapter 28A.710 RCW; and (g) through December 31, 2023, nonrepresented employees of an educational service district. "Employee" does not include: Adult family home providers; unpaid volunteers; patients of state hospitals; inmates; employees of the Washington state convention and trade center as provided in RCW 41.05.110; students of institutions of higher education as determined by their institution; and any others not expressly defined as employees under RCW 41.05.011 or by the authority under this chapter.

"Employer" for the public employees benefits board program means the state of Washington.

"Employer-based group health plan" means group medical and group dental related to a current employment relationship. It does not include medical or dental coverage available to retired employees, individual market medical or dental coverage, or government-sponsored programs such as medicare or medicaid.

"Employer-based group medical" means group medical related to a current employment relationship. It does not include medical coverage available to retired employees, individual market medical coverage, or government-sponsored programs such as medicare or medicaid.

"Employer contribution" means the funding amount paid to the HCA by a state agency or employer group for its eligible employees as described under WAC 182-12-114 and 182-12-131.

"Employer group" means those counties, municipalities, political subdivisions, the Washington health benefit exchange, tribal governments, employee organizations representing state civil service employees, and through December 31, 2019, school districts and charter schools, and through December 31, 2023, educational service districts obtaining employee benefits through a contractual agreement with the authority to participate in benefit plans developed by the public employees benefits board as described in WAC 182-08-245.

"Employer group rate surcharge" means the rate surcharge described in RCW 41.05.050(2).

"Employer-paid coverage" means PEBB insurance coverage for which an employer contribution is made by a state agency or an employer group for employees eligible under WAC 182-12-114 and 182-12-131. It also means SEBB insurance coverage for which an employer contribution is made by a SEBB organization, or basic benefits described in RCW 28A.400.270(1) for which an employer contribution is made by an educational service district.

"Employing agency" for the public employees benefits board program means a division, department, or separate agency of state government, including an institution of higher education; a county, municipality, or other political subdivision; and a tribal government covered by chapter 41.05 RCW.

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

"Exchange" means the Washington health benefit exchange established in RCW 43.71.020, and any other health benefit exchange established under the Affordable Care Act.

"Exchange coverage" means coverage offered by a qualified health plan through an exchange.

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

"Forms" or "form" means both paper forms and forms completed electronically.

"Health plan" means a plan offering medical or dental, or both, developed by the ((~~PEBB~~)) board and provided by a contracted vendor or self-insured plans administered by the HCA.

"Insignificant shortfall" means a premium balance owed that is less than or equal to the lesser of $50 or ten percent of the premium required by the health plan as described in Treasury Regulation 26 C.F.R. 54.4980B-8.

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

"Large claim" means a claim for more than $25,000 in allowed costs for services in a quarter.

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

"Life insurance" means basic life insurance paid for by the employing agency, as well as supplemental life insurance offered to and paid for by employees for themselves and their dependents. Life insurance for eligible retirees includes retiree term life insurance offered to and paid for by retirees.

"Long-term disability insurance" or "LTD insurance" means basic long-term disability insurance paid for by the employing agency and supplemental long-term disability insurance offered to and paid for by the employee.

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby eligible state employees may reduce their salary before taxes to pay for medical expenses not reimbursed by insurance as provided in the salary reduction plan established under chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"Ongoing large claim" means a claim where the patient is expected to need ongoing case management into the next quarter for which the expected allowed cost is greater than $25,000 in the quarter.

"PEBB" means the public employees benefits board.

"PEBB benefits" means one or more insurance coverages or other employee benefits administered by the PEBB program within the health care authority.

"PEBB insurance coverage" means any health plan, life insurance, accidental death and dismemberment insurance, long-term disability (LTD) insurance, long-term care insurance, or property and casualty insurance administered as a PEBB benefit.

"PEBB program" means the program within the HCA that administers insurance and other benefits for eligible employees (as described in WAC 182-12-114), eligible retired employees (as described in WAC 182-12-171 ((~~and~~)), 182-12-180, and 182-12-211), eligible survivors (as described in WAC 182-12-180, 182-12-250, and 182-12-265), eligible dependents (as described in WAC 182-12-250 and 182-12-260) and others as defined in RCW 41.05.011.

"Plan year" means the time period established by the authority.

"Premium payment plan" means a benefit plan whereby public employees may pay their share of group health plan premiums with pretax dollars as provided in the salary reduction plan under chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"Premium surcharge" means a payment required from a subscriber, in addition to the subscriber's medical premium contribution, due to an enrollee's tobacco use or an enrolled subscriber's spouse or state registered domestic partner choosing not to enroll in their employer-based group medical when:

• The spouse's or state registered domestic partner's share of the medical premium is less than ninety-five percent of the additional cost an employee would be required to pay to enroll a spouse or state registered domestic partner in the public employees benefits board (PEBB) Uniform Medical Plan (UMP) Classic; and

• The benefits have an actuarial value of at least ninety-five percent of the actuarial value of PEBB UMP Classic benefits.

"Public employee" has the same meaning as employee.

"Qualified health plan" means a medical plan that is certified to be offered through an exchange.

"Salary reduction plan" means a benefit plan whereby public employees may agree to a reduction of salary on a pretax basis to participate in the dependent care assistance program, medical flexible spending arrangement, or premium payment plan offered pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"Special open enrollment" means a period of time when subscribers may make changes to their health plan enrollment and salary reduction elections outside of the annual open enrollment period when specific life events occur. During the special open enrollment subscribers may change health plans and enroll or remove dependents from coverage. Additionally, employees may enroll in or waive enrollment in PEBB medical. Employees eligible to participate in the salary reduction plan may enroll in or revoke their election under the DCAP, medical FSA, or the premium payment plan and make a new election. For special open enrollment events related to specific PEBB benefits, see WAC 182-08-198, 182-08-199, 182-12-128, and 182-12-262.

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

"State registered domestic partner" has the same meaning as defined in RCW 26.60.020(1) and substantially equivalent legal unions from other jurisdictions as defined in RCW 26.60.090.

"Subscriber" means the employee, retiree, continuation coverage enrollee, or survivor who has been determined eligible by the PEBB program, employer group, or state agency, is enrolled in PEBB benefits, and is the individual to whom the PEBB program and contracted vendors will issue all notices, information, requests, and premium bills on behalf of an enrollee.

"Supplemental coverage" means any life insurance, accidental death and dismemberment (AD&D) insurance coverage, or long-term disability coverage purchased by the

employee in addition to the coverage provided by the employing agency.

"Tobacco products" means any product made with or derived from tobacco that is intended for human consumption, including any component, part, or accessory of a tobacco product. This includes, but is not limited to, cigars, cigarettes, pipe tobacco, chewing tobacco, snuff, and other tobacco products. It does not include e-cigarettes or United States Food and Drug Administration (FDA) approved quit aids.

"Tobacco use" means any use of tobacco products within the past two months. Tobacco use, however, does not include the religious or ceremonial use of tobacco.

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

"Waive" means an eligible employee affirmatively declining enrollment in ((~~a~~)) PEBB ((~~health~~)) medical plan because the employee is enrolled in other employer-based group medical, a TRICARE plan((~~s~~)), or medicare as allowed under WAC 182-12-128, or is on approved educational leave and obtains another employer-based group health plan as allowed under WAC 182-12-136.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-08-180 Premium payments and premium refunds. Public employees benefits board (PEBB) insurance coverage premiums and applicable premium surcharges for all subscribers are due as described in this section, except when an employing agency is correcting its enrollment error as described in WAC 182-08-187 (4) or (5).

(1) **Premium payments.** PEBB insurance coverage premiums and applicable premium surcharges for all subscribers become due the first of the month in which PEBB insurance coverage is effective.

Premiums and applicable premium surcharges are due from the subscriber for the entire month of PEBB insurance coverage and will not be prorated during any month.

(a) For subscribers not eligible for the employer contribution that are electing to enroll in PEBB retiree insurance coverage as described in WAC 182-12-171 (1)(a), 182-12-180 (3)(a), 182-12-200 (3)(a) or (b), 182-12-205 (6)(a) through (f), 182-12-211, and 182-12-265; or electing to enroll in continuation coverage as described in WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, and 182-12-270, the first premium payment and applicable premium surcharges are due to the health care authority (HCA) or the contracted vendor no later than forty-five days after the election period ends as described within the Washington Administrative Code applicable to the subscriber. Premiums and applicable premium surcharges associated with continuing PEBB medical must be made to the HCA as well as premiums associated with continuing PEBB dental or long-term disability insurance coverage. Premiums associated with life insurance and accidental death and dismemberment (AD&D) insurance coverage must be made to the contracted vendor. Following the first premium payment, premiums and applicable premium surcharges must be paid as premiums become due.

(b) For employees who are eligible for the employer contribution, premiums and applicable premium surcharges are due to the employing agency. If an employee elects supplemental coverage as described in WAC 182-08-197 (1)(a) or (3)(a), the employee is responsible for payment of premiums from the month that the supplemental coverage begins.

(c) Unpaid or underpaid premiums or applicable premium surcharges for all subscribers must be paid, and are due from the employing agency, subscriber, or a subscriber's legal representative to the HCA or contacted vendor. For subscribers not eligible for the employer contribution ((~~or employees eligible for the employer contribution as described in WAC 182-12-138~~)), monthly premiums or applicable premium surcharges that remain unpaid for thirty days will be considered delinquent. A subscriber is allowed a grace period of thirty days from the date the monthly premiums or applicable premium surcharges become delinquent to pay the unpaid premium balance or applicable premium surcharges. If a subscriber's monthly premiums or applicable premium surcharges remain unpaid for sixty days from the original due date, the subscriber's PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premiums and any applicable premium surcharges were paid. If it is determined by the HCA that payment of the unpaid balance in a lump sum would be considered a hardship, the HCA may develop a reasonable payment plan of up to twelve months in duration with the subscriber or the subscriber's legal representative upon request.

Exception: For a subscriber enrolled in a medicare advantage or a medicare advantage-prescription drug plan a notice will be sent to them notifying them that they are delinquent on their monthly premiums and that the enrollment will be terminated prospectively to the end of the month after the notice is sent.

(d) Monthly premiums or applicable premium surcharges due from a subscriber who is not eligible for the employer contribution will be considered unpaid if one of the following occurs:

(i) No payment of premiums or applicable premium surcharges are received by the HCA or contracted vendor and the monthly premiums or applicable premium surcharges remain unpaid for thirty days; or

(ii) Premium payments or applicable premium surcharges received by the HCA or contracted vendor are underpaid by an amount greater than an insignificant shortfall and the monthly premiums or applicable premium surcharges remain underpaid for thirty days past the date the monthly premiums or applicable premium surcharges were due.

(2) **Premium refunds.** PEBB insurance coverage premiums and applicable premium surcharges will be refunded using the following methods:

(a) When a subscriber submits an enrollment change affecting subscriber or dependent eligibility, HCA may allow up to three months of accounting adjustments. HCA will refund to the individual or the employing agency any excess premiums and applicable premium surcharges paid during

the three month adjustment period, except as indicated in WAC 182-12-148(5).

(b) If a PEBB subscriber, dependent, or beneficiary submits a written appeal as described in WAC 182-16-2010, and provides clear and convincing evidence of extraordinary circumstances, such that the subscriber could not timely submit the necessary information to accomplish an allowable enrollment change within sixty days after the event that created a change of premiums, the PEBB director, the PEBB director's designee, or the PEBB appeals unit may:

(i) Approve a refund of premiums and applicable premium surcharges which does not exceed twelve months of premiums; and

(ii) Approve the enrollment change that was originally requested and which forms the basis for the refund.

(c) If a federal government entity determines that an enrollee is retroactively enrolled in coverage (for example, medicare) the subscriber or beneficiary may be eligible for a refund of premiums and applicable premium surcharges paid during the time they were enrolled under the federal program if approved by the PEBB director or the PEBB director's designee.

(d) HCA errors will be corrected by returning all excess premiums and applicable premium surcharges paid by the employing agency, subscriber, or beneficiary.

(e) Employing agency errors will be corrected by returning all excess premiums and applicable premium surcharges paid by the employee or beneficiary as described in WAC 182-08-187 (4) and (5).

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-08-185 What are the requirements regarding premium surcharges? (1) A subscriber's account will incur a premium surcharge in addition to the subscriber's monthly medical premium, when any enrollee, thirteen years and older, engages in tobacco use.

(a) A subscriber must attest to whether any enrollee, thirteen years and older, enrolled in their public employees benefits board (PEBB) medical engages in tobacco use. The subscriber must attest as described in (a)(i) through (vii) of this subsection:

(i) An employee who is newly eligible or regains eligibility for the employer contribution toward PEBB benefits must complete the required form to enroll in PEBB medical as described in WAC 182-08-197 (1) or (3). The employee must include their attestation on that form. The employee must submit the form to their employing agency. If the employee's attestation results in a premium surcharge, it will take effect the same date as PEBB medical begins.

(ii) If there is a change in the tobacco use status of any enrollee, thirteen years and older on the subscriber's PEBB medical, the subscriber must update their attestation on the required form. An employee must submit the form to their employing agency. Any other subscriber must submit their form to the PEBB program. The attestation change will apply as follows:

• A change that results in a premium surcharge will begin the first day of the month following the status change. If that day is the first of the month, the change to the surcharge begins on that day.

• A change that results in removing the premium surcharge will begin the first day of the month following receipt of the attestation. If that day is the first of the month, the change to the surcharge begins on that day.

(iii) If a subscriber submits the required form to enroll a dependent, thirteen years and older, in PEBB medical as described in WAC 182-12-262, the subscriber must attest for their dependent on the required form. An employee must submit the form to their employing agency. Any other subscriber must submit their form to the PEBB program. A change that results in a premium surcharge will take effect the same date as PEBB medical begins.

(iv) An enrollee, thirteen years and older, who elects to continue medical coverage as described in WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, or 182-12-270, must provide an attestation on the required form if they have not previously attested as described in (a) of this subsection. The enrollee must submit their form to the PEBB program. An attestation that results in a premium surcharge will take effect the same date as PEBB medical begins.

(v) An employee or retiree who enrolls in PEBB medical as described in WAC 182-12-171 (1)(a), 182-12-180 (3)(a), 182-12-200 (3)(a) or (b), 182-12-205 (6)(a) through (f), or 182-12-211, must provide an attestation on the required form if they have not previously attested as described in (a) of this subsection. The employee or retiree must submit their form to the PEBB program. An attestation that results in a premium surcharge will take effect the same date as PEBB medical begins.

(vi) A surviving spouse, state registered domestic partner, or dependent child, thirteen years and older, who enrolls in PEBB medical as described in WAC 182-12-180 (3)(a), 182-12-250(5) or 182-12-265, must provide an attestation on the required form to the PEBB program if they have not previously attested as described in (a) of this subsection. An attestation that results in a premium surcharge will take effect the same date as PEBB medical begins.

(vii) An employee who previously waived PEBB medical must complete the required form to enroll in PEBB medical as described in WAC 182-12-128(3). The employee must include their attestation on that form. An employee must submit the form to their employing agency. An attestation that results in a premium surcharge will take effect the same date as PEBB medical begins.

Exceptions:

(1) A subscriber enrolled in both medicare Parts A and B and in the medicare risk pool as described in RCW 41.05.080(3) is not required to provide an attestation and no premium surcharge will be imposed on the subscriber's account.

(2) An employee who waives PEBB medical as described in WAC 182-12-128 is not required to provide an attestation and no premium surcharge will be applied to their account as long as the employee remains in waived status.

(b) A subscriber's account will incur a premium surcharge when a subscriber fails to attest to the tobacco use status of all enrollees as described in ((~~subsection (1)~~))(a) of this ((~~section~~)) subsection.

(c) The PEBB program will provide a reasonable alternative for enrollees who use tobacco products. A subscriber can avoid the tobacco use premium surcharge if the subscriber attests on the required form that all enrollees who use tobacco products enrolled in or accessed one of the applicable reasonable alternatives offered below:

(i) An enrollee who is eighteen years and older and uses tobacco products is currently enrolled in the free tobacco cessation program through their PEBB medical.

(ii) An enrollee who is thirteen through seventeen years old and uses tobacco products accessed the information and resources aimed at teens on the Washington state department of health's website at https://teen.smokefree.gov.

(iii) A subscriber may contact the PEBB program to accommodate a physician's recommendation that addresses an enrollee's use of tobacco products or for information on how to avoid the tobacco use premium surcharge.

(2) A subscriber will incur a premium surcharge in addition to the subscriber's monthly medical premium, if an enrolled spouse or state registered domestic partner has chosen not to enroll in another employer-based group medical where the spouse's or state registered domestic partner's share of the medical premium is less than ninety-five percent of the additional cost an employee would be required to pay to enroll a spouse or state registered domestic partner in the PEBB Uniform Medical Plan (UMP) Classic and the benefits have an actuarial value of at least ninety-five percent of the actuarial value of the PEBB UMP Classic's benefits.

(a) A subscriber who enrolled a spouse or state registered domestic partner under their PEBB medical may only attest during the following times:

(i) When a subscriber becomes eligible to enroll a spouse or state registered domestic partner in PEBB medical as described in WAC 182-12-262. The subscriber must complete the required form to enroll their spouse or state registered domestic partner, and include their attestation on that form. The employee must submit the form to their employing agency. Any other subscriber must submit the form to the PEBB program. If the subscriber's attestation results in a premium surcharge it will take effect the same date as PEBB medical begins;

(ii) During the annual open enrollment. A subscriber must attest if during the month prior to the annual open enrollment the subscriber was:

• Incurring the surcharge;

• Not incurring the surcharge because the spouse's or state registered domestic partner's share of the medical premium through their employer-based group medical was more than ninety-five percent of the additional cost an employee would be required to pay to enroll a spouse or state registered domestic partner in the PEBB UMP Classic; or

• Not incurring the surcharge because the actuarial value of benefits provided through the spouse's or state registered domestic partner's employer-based group medical was less than ninety-five percent of the actuarial value of the PEBB UMP Classic's benefits.

A subscriber must update their attestation on the required form. An employee must submit the form to their employing agency. Any other subscriber must submit the form to the PEBB program. The subscriber's attestation or any correction to a subscriber's attestation must be received no later than December 31st of the year in which the annual open enrollment occurs. If the subscriber's attestation results in a premium surcharge, being added or removed, the change to the surcharge will take effect January 1st of the following year; and

(iii) When there is a change in the spouse's or state registered domestic partner's employer-based group medical. A subscriber must update their attestation on the required form. An employee must submit the form to their employing agency no later than sixty days after the spouse's or state registered domestic partner's employer-based group medical status changes. Any other subscriber must submit the form to the PEBB program no later than sixty days after the spouse's or state registered domestic partner's employer-based group medical status changes.

• A change that results in a premium surcharge will begin the first day of the month following the status change. If that day is the first day of the month, the change to the premium surcharge begins on that day.

• A change that results in removing the premium surcharge will begin the first day of the month following receipt of the attestation. If that day is the first day of the month, the change to the premium surcharge begins on that day.

Exceptions:

(1) A subscriber enrolled in both medicare Parts A and B and in the medicare risk pool as described in RCW 41.05.080(3) is not required to provide an attestation and no premium surcharge will be imposed on the subscriber's account.

(2) An employee who waives PEBB medical as described in WAC 182-12-128 is not required to provide an attestation and no premium surcharge will be applied to their account as long as the employee remains in waived status.

(3) An employee who covers their spouse or state registered domestic partner who has waived their own PEBB medical must attest as described in this subsection, but will not incur a premium surcharge if the employee provides an attestation that their spouse or state registered domestic partner is eligible for PEBB ((~~coverage~~)) medical.

(4) A subscriber who covers their spouse or state registered domestic partner who elected not to enroll in a TRICARE plan must attest as described in this subsection, but will not incur a premium surcharge if the subscriber provides an attestation that their spouse or state registered domestic partner is eligible for a TRICARE plan.

(b) A premium surcharge will be applied to a subscriber who does not attest as described in (a) of this subsection.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-08-187 How do employing agencies and contracted vendors correct enrollment errors and is there a limit on retroactive enrollment? (1) An employing agency or contracted vendor that makes one or more of the following enrollment errors must correct the error as described in subsections (2) through ((~~(4)~~)) (5) of this section.

(a) Failure to timely notify an employee of their eligibility for public employee benefits board (PEBB) benefits and

the employer contribution as described in WAC 182-12-113(2);

(b) Failure to enroll the employee and their dependents in PEBB ((~~insurance coverage~~)) benefits as elected by the employee, if the elections were timely;

(c) Failure to enroll an employee and their dependents in PEBB ((~~insurance coverage~~)) benefits as described in WAC 182-08-197 (1)(b);

(d) Failure to accurately reflect an employee's premium surcharge attestation on the employee's account;

(e) Enrolling an employee or their dependent in PEBB insurance coverage when they are not eligible as described in WAC 182-12-114 or 182-12-260 and it is clear there was no fraud or intentional misrepresentation by the employee involved; or

(f) Providing incorrect information regarding PEBB benefits to the employee that they relied upon.

(2) The employing agency or the applicable contracted vendor must enroll the employee and the employee's dependents, as elected, or terminate enrollment in PEBB benefits as described in subsection (3) of this section, reconcile premium payments and applicable premium surcharges as described in subsection (4) of this section, and provide recourse as described in subsection (5) of this section.

((~~**Note:** If the employing agency failed to provide the notice required in WAC 182-12-113 or the employer group contract before the end of the employee's thirty-one day enrollment period described in WAC 182-08-197 (1)(a), the employing agency must provide the employee a written notice of eligibility for PEBB benefits and offer a new enrollment period of thirty-one days. Employees who do not return the required enrollment forms by the due date required under the new enrollment period must be defaulted according to WAC 182-08-197 (1)(b). This notice requirement does not remove the ability to offer recourse.~~))

(3) **Enrollment or termination.**

(a) PEBB medical and dental enrollment is effective at a minimum the first day of the month following the date the enrollment error is identified, unless the authority determines additional recourse is warranted, as described in subsection (5) of this section. If the enrollment error is identified on the first day of the month, the enrollment correction is effective that day;

(b) Basic life, basic accidental death and dismemberment (AD&D), and basic long-term disability (LTD) insurance enrollment is retroactive to the first day of the month following the day the employee became newly eligible, or the first day of the month the employee regained eligibility, as described in WAC 182-08-197. If the employee became newly eligible on the first working day of a month, basic life, basic AD&D, and basic LTD insurance begins on that date;

(c) Supplemental life, supplemental AD&D, and supplemental LTD insurance enrollment is retroactive to the first day of the month following the day the employee became newly eligible if the employee elects to enroll in this coverage (or if previously elected, the first of the month following the signature date ((~~of~~)) on the employee's application for this coverage). If an employing agency enrollment error occurred when the employee regained eligibility for the employer contribution following a period of leave as described in WAC 182-08-197(3):

(i) Supplemental life, supplemental AD&D, and supplemental LTD insurance is enrolled the first day of the month the employee regained eligibility, at the same level of coverage the employee continued during the period of leave, without evidence of insurability.

(ii) If the employee was not eligible to continue supplemental LTD insurance during the period of leave as described in WAC 182-12-133, supplemental LTD insurance is reinstated the first day of the month the employee regained eligibility, to the level of coverage the employee was enrolled in prior to the period of leave, without evidence of insurability.

(iii) If the employee was eligible to continue supplemental life insurance, supplemental AD&D insurance, and supplemental LTD insurance under the period of leave but did not, the employee must provide evidence of insurability and receive approval from the contracted vendor.

(d) If the employee is eligible and elects (or elected) to enroll in the medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP), enrollment is limited to three months prior to the date enrollment is processed, but not earlier than the current plan year. If an employee was not enrolled in a medical FSA or DCAP as elected, the employee may either participate at the amount originally elected with a corresponding increase in contributions for the balance of the plan year, or participate at a reduced amount for the plan year by maintaining the per-pay period contribution in effect;

(e) If the employee or their dependent was not eligible but still enrolled as described in subsection (1)(e) of this section, the employee's or their dependent's PEBB ((~~insurance coverage~~)) benefits will be terminated prospectively effective as of the last day of the month.

(4) **Premium payments.**

(a) The employing agency must remit to the authority the employer contribution and the employee contribution for health plan premiums, applicable premium surcharges, basic life, basic AD&D, and basic LTD starting the date PEBB ((~~insurance coverage~~)) benefits begins as described in subsections (3) and (5)(a)(i) of this section. If a state agency failed to notify a newly eligible employee of their eligibility for PEBB benefits, the state agency may only collect the employee contribution for health plan premiums and applicable premium surcharges for coverage for the months ((~~following notification of a new enrollment period~~)) after the employee was notified.

(b) When an employing agency fails to correctly enroll the amount of supplemental LTD insurance elected by the employee, premiums will be corrected as follows:

(i) When additional premiums are due to the authority, the employee is responsible for premiums for the most recent twenty-four months of coverage. The employing agency is responsible for additional months of premiums.

(ii) When a premium refund((~~s are~~)) is due to the employee, the supplemental LTD insurance contracted vendor is responsible for premium refunds for the most recent twenty-four months of coverage. The employing agency is responsible for additional months of premium refund((~~s~~)).

(c) When an employing agency mistakenly enrolls an employee or their dependent as described in subsection (1)(e) of this section, premiums and any applicable premium sur-

charges will be refunded by the employing agency to the employee without rescinding the insurance coverage.

(5) **Recourse.**

(a) Employee eligibility for PEBB benefits begins on the first day of the month following the date eligibility is established as described in WAC 182-12-114. Dependent eligibility is described in WAC 182-12-260, and dependent enrollment is described in WAC 182-12-262. When retroactive correction of an enrollment error is limited as described in subsection (3)(b), (c) and (d) of this section, the employing agency must work with the employee, and receive approval from the authority, to implement retroactive PEBB ((~~insurance coverage~~)) benefits within the following parameters:

(i) Retroactive enrollment in a PEBB ((~~health plan~~)) insurance coverage;

(ii) Reimbursement of claims paid;

(iii) Reimbursement of amounts paid by the employee or dependent for medical and dental premiums;

(iv) Reimbursement of amounts paid by the employee for the premium surcharges;

(v) Other legal remedy received or offered; or

(((~~v~~))) (vi) Other recourse, upon approval by the authority.

(b) Recourse must not contradict a specific provision of federal law or statute and does not apply to requests for noncovered services or in the case of an individual who is not eligible for PEBB benefits.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-08-190 The employer contribution is set by the health care authority (HCA) and paid to the HCA for all eligible employees. State agencies and employer groups that participate in the public employees benefits board (PEBB) program under contract with the health care authority (HCA) must pay the employer contributions to the ((~~health care authority (~~))HCA((~~)~~)) for PEBB ((~~insurance coverage~~)) for all eligible employees and their enrolled dependents.

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

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

(3) Each employee of a state agency eligible under WAC 182-12-131 or each eligible employee of a state agency on leave under the federal Family and Medical Leave Act (FMLA) or the paid family and medical leave program is eligible for the employer contribution as described in WAC 182-12-138. ((~~The entire employer contribution is due and payable to HCA even if PEBB medical is waived as described in WAC 182-12-128.~~))

(4) Employees of employer groups eligible under criteria stipulated under contract with the HCA are eligible for the employer contribution.

(5) The entire employer contribution is due and payable to the HCA even if PEBB medical is waived as described in WAC 182-12-128.

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

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

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-08-191 Subscriber address requirements. (1) All employees must provide their employing agency with their correct address and update their address if it changes. A subscriber on public employees benefits board (PEBB) retiree insurance coverage, or continuation coverage must provide the PEBB program with their correct address and updates to their address if it changes.

(2) ((~~Employees who are appealing a decision to the public employees benefits board (PEBB) program~~)) In the event of an appeal, appellants must update their address as required in WAC 182-16-055.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-08-196 What happens if my health plan becomes unavailable due to a change in contracted service area or eligibility for medicare? (1) A subscriber must elect a new health plan when their previously selected health plan becomes unavailable due to a change in contracting service area as described below:

(a) When a health plan becomes unavailable during the plan year, a subscriber must elect a new health plan no later than sixty days after the date their previously selected health plan becomes unavailable.

(i) An employee must submit the required forms to their employing agency electing their new health plan.

(ii) Any other subscriber must submit the required forms to the PEBB program electing their new health plan.

(iii) The effective date of the change in health plan will be the first day of the month following the later of the date the health plan becomes unavailable or the date the form is received. If that day is the first of the month, the change in health plan begins on that day.

(b) When a health plan becomes unavailable at the beginning of the next plan year, a subscriber must elect a new health plan no later than the last day of the public employees benefits board (PEBB) annual open enrollment.

(i) An employee must submit the required forms to their employing agency electing their new health plan.

(ii) Any other subscriber must submit the required forms to the PEBB program electing their new health plan.

(iii) The effective date of the change in health plan will be January 1st of the following year.

(c) A subscriber who fails to elect a new health plan within the required time period as required in (a) or (b) of this subsection will be enrolled in a health plan designated by the director or designee.

(2) A subscriber must elect a new health plan when their previously selected health plan becomes unavailable due to the subscriber or subscriber's dependent ceasing to be eligible for their current health plan because of enrollment in medicare as described below:

(a) The required forms electing a new health plan must be received no later than sixty days after the date their previously selected health plan becomes unavailable.

Exception: The required forms electing a new medicare advantage plan must be received no later than two months after the date their previously selected health plan becomes unavailable.

(b) An employee must submit the required forms to their employing agency electing their new health plan.

(c) Any other subscriber must submit the required forms to the PEBB program electing their new health plan.

(d) The effective date of the change in health plan will be the first day of the month following the later of the date the health plan becomes unavailable or the date the form is received. If that day is the first of the month, the change in health plan begins on that day.

(e) A subscriber who is enrolled in a ((~~consumer directed~~)) high deductible health plan (((~~(CDHP)~~))) (HDHP) with a health savings account (HSA), ((~~who~~)) and fails to elect a new health plan within the required time period as required in this subsection, will not be eligible to receive contributions to the HSA. A subscriber will be liable for any tax penalties resulting from contributions made when they are no longer eligible.

(3) A subscriber enrolled in a health plan as described in subsection (1)(c) or (2)(e) of this section may not change health plans except as allowed in WAC 182-08-198.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

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

(1) **During the annual open enrollment:** A subscriber may change health plans during the public employees benefits board (PEBB) annual open enrollment period. A subscriber must submit the required enrollment forms to change their health plan. An employee submits the enrollment forms to their employing agency. Any other subscriber submits the enrollment forms to the PEBB program. The required enrollment forms must be received no later than the last day of the annual open enrollment. Enrollment in the new health plan will begin January 1st of the following year.

(2) **During a special open enrollment:** A subscriber may revoke their health plan election and make a new election outside of the annual open enrollment if a special open enrollment event occurs. A special open enrollment event must be an event other than an employee gaining initial eligibility for PEBB benefits as described in WAC 182-12-114 or regaining eligibility for PEBB benefits as described in WAC 182-08-197. The change in enrollment must be allowable under Internal Revenue Code and Treasury regulations, and correspond to and be consistent with the event that creates the special open enrollment for the subscriber, the subscriber's dependent, or both. To disenroll from a medicare advantage plan or medicare advantage-prescription drug plan, the change in enrollment must be allowable under 42 C.F.R. Sec. 422.62(b) and 42 C.F.R. Sec. 423.38(c). To make a health plan change, a subscriber must submit the required enrollment forms (and a completed disenrollment form, if required). The forms must be received no later than sixty days after the event occurs, except as described in (i) of this subsection. An employee submits the enrollment forms to their employing agency. Any other subscriber submits the enrollment forms to the PEBB program. In addition to the required forms, a subscriber must provide evidence of the event that created the special open enrollment. New health plan coverage will begin the first day of the month following the later of the event date or the date the form is received. If that day is the first of the month, the change in enrollment begins on that day.

Exception: When a subscriber or their dependent is enrolled in a medicare advantage or medicare advantage-prescription drug plan, they may disenroll during a special enrollment period as allowed under Title 42 C.F.R. The new ((~~health~~)) medical plan coverage will begin the first day of the month following the date the medicare advantage plan disenrollment form is received.

If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, health plan coverage will begin the month in which the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption occurs. If the special open enrollment is due to the enrollment of an extended dependent or a dependent with a disability, the change in health plan coverage will begin the first day of the month following the later of the event date or eligibility certification. Any one of the following events may create a special open enrollment:

(a) Subscriber acquires a new dependent due to:

(i) Marriage or registering a state registered domestic partnership;

(ii) Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or

(iii) A child becoming eligible as an extended dependent through legal custody or legal guardianship.

(b) Subscriber or a subscriber's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);

(c) Subscriber has a change in employment status that affects the subscriber's eligibility for their employer contribution toward their employer-based group health plan;

(d) The subscriber's dependent has a change in their own employment status that affects their eligibility for the

employer contribution under their employer-based group health plan;

Note: As used in (d) of this subsection, "employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 26 C.F.R. 54.9801-6.

(e) Subscriber or a subscriber's dependent has a change in residence that affects health plan availability. If the subscriber moves and the subscriber's current health plan is not available in the new location the subscriber must select a new health plan, otherwise there will be limited accessibility to network providers and covered services;

Exception: A dental plan is considered available if a provider is located within fifty miles of the subscriber's new residence.

(f) A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state registered domestic partner is not an eligible dependent);

(g) Subscriber or a subscriber's dependent ((~~becomes entitled to~~)) enrolls in coverage under medicaid or a state children's health insurance program (CHIP), or the subscriber or a subscriber's dependent loses eligibility for coverage under medicaid or CHIP;

(h) Subscriber or a subscriber's dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from medicaid or CHIP;

(i) Subscriber or a subscriber's dependent ((~~becomes entitled to~~)) enrolls in coverage under medicare, or the subscriber or a subscriber's dependent loses eligibility for coverage under medicare, or enrolls in or terminates enrollment in a medicare advantage-prescription drug or a Part D plan. If the subscriber's current ((~~health~~)) medical plan becomes unavailable due to the subscriber's or a subscriber's dependent's ((~~entitlement to~~)) enrollment in medicare, the subscriber must select a new ((~~health~~)) medical plan as described in WAC 182-08-196(2).

(i) A subscriber enrolled in PEBB retiree insurance coverage or an eligible subscriber enrolled in Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage has six months from the date of their or their dependent's enrollment in medicare Part B to enroll in a PEBB medicare supplement plan for which they or their dependent is eligible. The forms must be received by the PEBB program no later than six months after the enrollment in medicare Part B for either the subscriber or the subscriber's dependent;

(ii) A subscriber enrolled in PEBB retiree insurance coverage or an eligible subscriber enrolled in Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage has seven months to enroll in a medicare advantage or medicare advantage-prescription drug plan that begins three months before they or their dependent first enrolled in both medicare Part A and Part B and ends three months after the month of medicare eligibility. A subscriber may also enroll themselves or their dependent in a medicare advantage or medicare advantage-prescription drug plan before their last day of the medicare Part B initial enrollment period. The forms must be received by the PEBB program no later than the last day of the month prior to the month the subscriber or the subscriber's dependent enrolls in the medicare advantage or medicare advantage-prescription drug plan.

(j) Subscriber or a subscriber's dependent's current ((~~health~~)) medical plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA). The authority may require evidence that the subscriber or subscriber's dependent is no longer eligible for an HSA;

(k) Subscriber or a subscriber's dependent experiences a disruption of care for active and ongoing treatment, that could function as a reduction in benefits for the subscriber or the subscriber's dependent. A subscriber may not change their health plan election if the subscriber's or dependent's physician stops participation with the subscriber's health plan unless the PEBB program determines that a continuity of care issue exists. The PEBB program will consider but not limit its consideration to the following:

(i) Active cancer treatment such as chemotherapy or radiation therapy;

(ii) Treatment following a recent organ transplant;

(iii) A scheduled surgery;

(iv) Recent major surgery still within the postoperative period; or

(v) Treatment for a high-risk pregnancy.

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

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-08-199 When may an employee enroll, or revoke an election and make a new election under the premium payment plan, medical flexible spending arrangement (FSA), or dependent care assistance program (DCAP)? An employee who is eligible to participate in the salary reduction plan as described in WAC 182-12-116 may enroll, or revoke their election and make a new election under the premium payment plan, medical flexible spending arrangement (FSA), or dependent care assistance program (DCAP) at the following times:

(1) When newly eligible under WAC 182-12-114 and enrolling as described in WAC 182-08-197(1).

(2) **During annual open enrollment:** An eligible employee may elect to enroll in or opt out of participation under the premium payment plan during the annual open enrollment by submitting the required form to their employing agency. An eligible employee may elect to enroll or reenroll in the medical FSA, DCAP, or both during the annual open enrollment by submitting the required forms to their employing agency or applicable contracted vendor as instructed. All required forms must be received no later than the last day of the annual open enrollment. The enrollment or new election becomes effective January 1st of the following year.

Note: Employees enrolled in a consumer directed health plan (CDHP) with a health savings account (HSA) cannot also enroll in a medical FSA in the same plan year. Employees who elect both will only be enrolled in the CDHP with a HSA.

(3) **During a special open enrollment:** An employee who is eligible to participate in the salary reduction plan may enroll or revoke their election and make a new election under the premium payment plan, medical FSA, or DCAP outside of the annual open enrollment if a special open enrollment event occurs. The enrollment or change in election must be allowable under Internal Revenue Code (IRC) and Treasury regulations, and correspond to and be consistent with the event that creates the special open enrollment. To make a change or enroll, the employee must submit the required form to their employing agency. The employing agency must receive the required form and evidence of the event that created the special open enrollment no later than sixty days after the event occurs.

For purposes of this section, an eligible dependent includes any person who qualifies as a dependent of the employee for tax purposes under IRC 26 U.S.C. Sec. 152 without regard to the income limitations of that section. It does not include a state registered domestic partner unless the state registered domestic partner otherwise qualifies as a dependent for tax purposes under IRC 26 U.S.C. Sec. 152.

(a) **Premium payment plan.** An employee may enroll or revoke their election and elect to opt out of the premium payment plan when any of the following special open enrollment events occur, if the requested change corresponds to and is consistent with the event. The enrollment or election to opt out will be effective the first day of the month following the later of the event date or the date the required form is received. If that day is the first of the month, the enrollment or change in election begins on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, the enrollment or change in election will begin the first of the month in which the event occurs.

(i) Employee acquires a new dependent due to:

• Marriage;

• Registering a state registered domestic partnership when the dependent is a tax dependent of the employee;

• Birth, adoption, or when the employee has assumed a legal obligation for total or partial support in anticipation of adoption; or

• A child becoming eligible as an extended dependent through legal custody or legal guardianship.

(ii) Employee's dependent no longer meets public employee benefits board (PEBB) eligibility criteria because:

• Employee has a change in marital status;

• Employee's domestic partnership with a state registered domestic partner who is a tax dependent is dissolved or terminated;

• An eligible dependent child turns age twenty-six or otherwise does not meet dependent child eligibility criteria;

• An eligible dependent ceases to be eligible as an extended dependent or as a dependent with a disability; or

• An eligible dependent dies.

(iii) Employee or an employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);

(iv) Employee has a change in employment status that affects the employee's eligibility for their employer contribution toward their employer-based group health plan;

(v) The employee's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan;

Note: As used in (a)(v) of this subsection, "employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 26 C.F.R. 54.9801-6.

(vi) Employee or an employee's dependent has a change in enrollment under an employer-based group health plan during its annual open enrollment that does not align with the PEBB annual open enrollment;

(vii) Employee or an employee's dependent has a change in residence that affects health plan availability;

(viii) Employee's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States and that change in residence resulted in the dependent losing their health insurance;

(ix) A court order requires the employee or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state registered domestic partner is not an eligible dependent);

(x) Employee or an employee's dependent ((~~becomes entitled to~~)) enrolls in coverage under medicaid or a state children's health insurance program (CHIP), or the subscriber or a subscriber's dependent loses eligibility for coverage under medicaid or CHIP;

(xi) Employee or an employee's dependent becomes eligible for state premium assistance subsidy for PEBB ((~~health~~)) medical plan coverage from medicaid or CHIP;

(xii) Employee or an employee's dependent ((~~becomes entitled to~~)) enrolls in coverage under medicare or the employee or an employee's dependent loses eligibility for coverage under medicare;

(xiii) Employee or an employee's dependent's current ((~~health~~)) medical plan becomes unavailable because the employee or enrolled dependent is no longer eligible for a health savings account (HSA). The health care authority (HCA) requires evidence that the employee or employee's dependent is no longer eligible for an HSA;

(xiv) Employee or an employee's dependent experiences a disruption of care for active and ongoing treatment, that could function as a reduction in benefits for the employee or the employee's dependent. The employee may not change their health plan election if the employee's or dependent's physician stops participation with the employee's health plan unless the PEBB program determines that a continuity of care issue exists. The PEBB program will consider but not limit its consideration to the following:

• Active cancer treatment such as chemotherapy or radiation therapy;

• Treatment following a recent organ transplant;

• A scheduled surgery;

• Recent major surgery still within the postoperative period; or

• Treatment for a high-risk pregnancy.

(xv) Employee or employee's dependent becomes eligible and enrolls in a TRICARE plan, or loses eligibility for a TRICARE plan.

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

(b) **Medical FSA.** An employee may enroll or revoke their election and make a new election under the medical FSA when any one of the following special open enrollment events occur, if the requested change corresponds to and is consistent with the event. The enrollment or new election will be effective the first day of the month following the later of the event date or the date the required form and evidence of the event that created the special open enrollment is received by the employing agency. If that day is the first of the month, the enrollment or change in election begins on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, the enrollment or change in election will begin the first of the month in which the event occurs.

(i) Employee acquires a new dependent due to:

• Marriage;

• Registering a state registered domestic partnership if the domestic partner qualifies as a tax dependent of the employee;

• Birth, adoption, or when the employee has assumed a legal obligation for total or partial support in anticipation of adoption; or

• A child becoming eligible as an extended dependent through legal custody or legal guardianship.

(ii) Employee's dependent no longer meets PEBB eligibility criteria because:

• Employee has a change in marital status;

• Employee's domestic partnership with a state registered domestic partner who qualifies as a tax dependent is dissolved or terminated;

• An eligible dependent child turns age twenty-six or otherwise does not meet dependent child eligibility criteria;

• An eligible dependent ceases to be eligible as an extended dependent or as a dependent with a disability; or

• An eligible dependent dies.

(iii) Employee or an employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the ((~~Health Insurance Portability and Accountability Act (~~))HIPAA((~~)~~)));

(iv) Employee or an employee's dependent has a change in employment status that affects the employee's or a dependent's eligibility for the medical FSA;

(v) A court order requires the employee or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state registered domestic partner is not an eligible dependent);

(vi) Employee or an employee's dependent ((~~becomes entitled to~~)) enrolls in coverage under medicaid or a state children's health insurance program (CHIP), or the employee or an employee's dependent loses eligibility for coverage under medicaid or CHIP;

(vii) Employee or an employee's dependent ((~~becomes entitled to~~)) enrolls in coverage under medicare.

(c) **DCAP.** An employee may enroll or revoke their election and make a new election under the DCAP when any one of the following special open enrollment events occur, if the requested change corresponds to and is consistent with the event. The enrollment or new election will be effective the first day of the month following the later of the event date or the date the required form and evidence of the event that created the special open enrollment is received by the employing agency. If that day is the first of the month, the enrollment or change in election begins on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, the enrollment or change in election will begin the first of the month in which the event occurs.

(i) Employee acquires a new dependent due to:

• Marriage;

• Registering a state registered domestic partnership if the domestic partner qualifies as a tax dependent of the employee;

• Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or

• A child becoming eligible as an extended dependent through legal custody or legal guardianship.

(ii) Employee or an employee's dependent has a change in employment status that affects the employee's or a dependent's eligibility for DCAP;

(iii) Employee or an employee's dependent has a change in enrollment under an employer-based group health plan during its annual open enrollment that does not align with the PEBB annual open enrollment;

(iv) Employee changes dependent care provider; the change to the DCAP election amount can reflect the cost of the new provider;

(v) Employee or the employee's spouse experiences a change in the number of qualifying individuals as defined in IRC 26 U.S.C. Sec. 21 (b)(1);

(vi) Employee's dependent care provider imposes a change in the cost of dependent care; employee may make a change in the DCAP election amount to reflect the new cost if the dependent care provider is not a qualifying relative of the employee as defined in IRC 26 U.S.C. Sec. 152.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-08-235 Employer group and board of directors for school districts and educational service districts application process. This section applies to employer groups as defined in WAC 182-08-015 and board members of school districts and educational service districts. An employer group or board member of a school district or an educational service district may apply to obtain public employees benefits board (PEBB) insurance coverage through a contract with the health care authority (HCA).

(1) Employer groups and board members of school districts and educational service districts with less than five hundred employees must apply at least sixty days before the

requested coverage effective date. Employer groups with five hundred or more employees but with less than five thousand employees must apply at least ninety days before the requested effective date.

Employer groups with five thousand or more employees must apply at least one hundred twenty days before the requested coverage effective date. To apply, employer groups must submit the documents and information described in subsection (2) of this section to the PEBB program as follows:

(a) Board members of school districts and educational service districts and educational service districts applying for ((~~its~~)) their nonrepresented employees are required to provide the documents described in subsection((~~s~~)) (2)(a) through (c) of this section;

Exception: Educational service districts required by the superintendent of public instruction to purchase PEBB insurance coverage provided by the authority are required to submit documents and information described in subsection (2)(a)(iii), (b), and (c) of this section.

(b) Counties, municipalities, political subdivisions, and tribal governments with fewer than five thousand employees are required to provide the documents and information described in subsection (2)(a) through (f) of this section;

(c) Counties, municipalities, political subdivisions, and tribal governments with five thousand or more employees will have their application approved or denied through the evaluation criteria described in WAC 182-08-240 and are required to provide the documents and information described in subsection (2)(a) through (d), (f), and (g) of this section; and

(d) All employee organizations representing state civil services employees and the Washington health benefit exchange, regardless of the number of employees, will have their application approved or denied through the evaluation criteria described in WAC 182-08-240 and are required to provide the documents and information described in subsection (2)(a) through (d), (f), and (g) of this section.

(2) Documents and information required with application:

(a) A letter of application that includes the information described in (a)(i) through (iv) of this subsection:

(i) A reference to the group's authorizing statute;

(ii) A description of the organizational structure of the group and a description of the employee bargaining unit or group of nonrepresented employees for which the group is applying;

(iii) Employer group or board members of school district or educational service district tax ID number (TIN); and

(iv) A statement of whether the group is applying to obtain only medical or all available PEBB insurance coverages. Educational service districts applying for its nonrepresented employees must purchase medical, dental, life, and long-term disability insurance. Board members of school districts or educational service districts must provide a statement of whether the group is applying to obtain medical, dental, and life insurance.

(b) A resolution from the group's governing body authorizing the purchase of PEBB insurance coverage.

(c) A signed governmental function attestation document that attests to the fact that employees for whom the group is applying are governmental employees whose services are substantially all in the performance of essential governmental functions.

(d) A member level census file for all of the employees for whom the group is applying. The file must be provided in the format required by the authority and contain the following demographic data, by member, with each member classified as employee, spouse or state registered domestic partner, or child:

(i) Employee ID (any identifier which uniquely identifies the employee; for dependents the employee's unique identifier must be used);

(ii) Age;

(iii) ((~~Gender~~)) Birth sex;

(iv) First three digits of the member's zip code based on residence;

(v) Indicator of whether the employee is active or retired, if the group is requesting to include retirees; and

(vi) Indicator of whether the member is enrolled in coverage.

(e) Historical claims and cost information that include the following:

(i) Large claims history for twenty-four months by quarter that excludes the most recent three months;

(ii) Ongoing large claims management report for the most recent quarter provided in the large claims history;

(iii) Summary of historical plan costs; and

(iv) The director or the director's designee may make an exception to the claims and cost information requirements based on the size of the group, except that the current health plan does not have a case management program, then the primary diagnosis code designated by the authority must be reported for each large claimant. If the code indicates a condition which is expected to continue into the next quarter, the claim is counted as an ongoing large claim. If historical claims and cost information as described in (e)(i) through (iii) of this subsection are unavailable, the director or the director's designee may make an exception to allow all of the following alternative requirements:

• A letter from their carrier indicating they will not or cannot provide claims data.

• Provide information about the health plan most employees are enrolled in by completing the actuarial calculator authorized by the PEBB program.

• Current premiums for the health plan.

(f) If the application is for a subset of the group's employees (e.g., bargaining unit), the group must provide a member level census file of all employees eligible under their current health plan who are not included on the member level census file in (d) of this subsection. This includes retired employees participating under the group's current health plan. The file must include the same demographic data by member.

(g) Employer groups described in subsection (1)(c) and (d) of this section must submit to an actuarial evaluation of the group provided by an actuary designated by the PEBB program. The group must pay for the cost of the evaluation. This cost is nonrefundable. A group that is approved will not have to pay for an additional actuarial evaluation if it applies to add another bargaining unit within two years of the evalu-

ation. Employer groups of this size must provide the following:

(i) Large claims history for twenty-four months, by quarter that excludes the most recent three months;

(ii) Ongoing large claims management report for the most recent quarter provided in the large claims history;

(iii) Executive summary of benefits;

(iv) Summary of benefits and certificate of coverage; and

(v) Summary of historical plan costs.

Exception: If the current health plan does not have a case management program then the primary diagnosis code designated by the authority must be reported for each large claimant. If the code indicates a condition which is expected to continue into the next quarter, the claim is counted as an ongoing large claim.

(3) The authority may automatically deny a group application if the group fails to provide the required information and documents described in this section.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-08-245 Employer group and board members of school districts and educational service districts participation requirements. This section applies to an employer group as defined in WAC 182-08-015 or board members of school districts or educational service districts that is approved to purchase insurance for its employees through a contract with the health care authority (HCA).

(1) Prior to enrollment of employees in public employees benefits board (PEBB) insurance coverage, the employer group or board members of school districts or educational service districts must:

(a) Remit to the authority the required start-up fee in the amount publicized by the PEBB program;

(b) Sign a contract with the authority;

(c) Determine employee and dependent eligibility and terms of enrollment for PEBB insurance coverage by the criteria outlined in this chapter and chapter 182-12 WAC unless otherwise approved by the authority in the employer group's contract with the authority;

(d) Determine eligibility in order to ensure the PEBB program's continued status as a governmental plan under Section 3(32) of the Employee Retirement Income Security Act of 1974 (ERISA) as amended. This means the employer group may only consider employees whose services are substantially all in the performance of essential governmental functions, but not in the performance of commercial activities, whether or not those activities qualify as essential governmental functions to be eligible; and

(e) Ensure PEBB insurance coverage is the only employer-sponsored coverage available to groups of employees eligible for PEBB insurance coverage under the contract.

(2) Pay premiums under its contract with the authority based on the following premium structure:

(a) The premium rate structure for educational service districts purchasing PEBB insurance coverage for nonrepresented employees will be a composite rate equal to the rate charged to state agencies plus an amount equal to the employee premium based on health plan election and family enrollment. Educational service districts must collect an amount equal to the premium surcharges applied to an employee's account by the authority from their nonrepresented employees and include the funds in their payment to the authority.

Exception: The authority will allow educational service districts that enrolled prior to September 1, 2002, to continue participation based on a tiered rate structure. The authority may require the district to change to a composite rate structure with ninety days advance written notice.

(b) The premium rate structure for employer groups other than educational service districts described in (a) of this subsection and board members of school districts and educational service districts will be a tiered rate based on health plan election and family enrollment. Employer groups must collect an amount equal to the premium surcharges applied to an employee's account by the authority from their employees and include the funds in their payment to the authority.

Exception: The authority will allow employer groups that enrolled prior to January 1, 1996, to continue to participate based on a composite rate structure. The authority may require the employer group to change to a tiered rate structure with ninety days advance written notice.

(3) Counties, municipalities, political subdivisions, and tribal governments must pay the monthly employer group rate surcharge in the amount invoiced by the authority.

(4) If an employer group or board member of school districts and educational service districts want((s)) to make subsequent changes to the contract, the changes must be submitted to the authority for approval.

(5) The employer group or board members of school districts and educational service districts must maintain participation in PEBB insurance coverage for at least one full year. An employer group or board members of school districts and educational service districts may only end participation at the end of a plan year unless the authority approves a mid-year termination. To end participation, an employer group or member of school districts and educational service districts must provide written notice to the PEBB program at least sixty days before the requested termination date.

(6) Upon approval to purchase insurance through a contract with the authority, the employer group must provide a list of employees and dependents that are enrolled in Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage and the remaining number of months available to them based on their qualifying event. These employees and dependents may enroll in a PEBB health plan as COBRA subscribers for the remainder of the months available to them based on their qualifying event.

(7) Enrollees in PEBB insurance coverage under one of the continuation of coverage provisions allowed under chapter 182-12 WAC or retirees included in the transfer unit as allowed under WAC 182-08-237 cease to be eligible as of the last day of the contract and may not continue enrollment beyond the end of the month in which the contract is terminated.

Exception: If an employer group, other than an educational service district, ends participation, retired and disabled employees who began participation before September 15, 1991, are eligible to continue enrollment in PEBB insurance coverage if the employee continues to meet the procedural and eligibility requirements of WAC 182-12-171. Employees who enrolled after September 15, 1991, who are enrolled in PEBB retiree insurance coverage cease to be eligible under WAC 182-12-171, but may continue health plan enrollment under COBRA (see WAC 182-12-146).

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

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

"Accidental death and dismemberment insurance" or "AD&D" means basic accidental death and dismemberment (AD&D) insurance paid for by the employing ((~~agencies~~)) agency, as well as supplemental accidental death and dismemberment insurance offered to and paid for by employees for themselves and their dependents.

"Affordable Care Act" means the federal Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, P.L. 111-152, or federal regulations or guidance issued under the Affordable Care Act.

"Annual open enrollment" means an annual event set aside for a period of time by the HCA when subscribers may make changes to their health plan enrollment and salary reduction elections for the following plan year. During the annual open enrollment, subscribers may transfer from one health plan to another, enroll or remove dependents from coverage, enroll in coverage, or waive enrollment in PEBB medical. Employees eligible to participate in the salary reduction plan may enroll in or change their election under the dependent care assistance program (DCAP) or the medical flexible spending arrangement (FSA). They may also enroll in or opt out of the premium payment plan.

"Authority" or "HCA" means the Washington state health care authority.

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

"Blind vendor" means a "licensee" as defined in RCW 74.18.200.

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

"Calendar days" or "days" means all days including Saturdays, Sundays, and all ((~~legal~~)) state legal holidays as set forth in RCW 1.16.050.

"Consolidated Omnibus Budget Reconciliation Act" or "COBRA" means continuation coverage as administered under 42 U.S.C. Secs. 300bb-1 through 300bb-8.

"Continuation coverage" means the temporary continuation of ((~~health plan coverage~~)) PEBB benefits available to enrollees under the Consolidated Omnibus Budget Reconciliation Act (COBRA), 42 U.S.C. Secs. 300bb-1 through 300bb-8, the Uniformed Services Employment and Reemployment Rights Act (USERRA), 38 U.S.C. Secs. 4301 through 4335, or the public employees benefits board's policies.

"Contracted vendor" means any person, persons, or entity under contract or agreement with the HCA to provide goods or services for the provision or administration of PEBB benefits. The term "contracted vendor" includes subcontractors of the HCA and subcontractors of any person, persons, or entity under contract or agreement with the HCA that provide goods or services for the provision or administration of PEBB benefits.

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

"Defer" means to postpone enrollment or interrupt enrollment in ((~~a PEBB health plan~~)) PEBB insurance coverage by a retiree or an eligible survivor.

"Dependent" means a person who meets eligibility requirements in WAC 182-12-260, except that "surviving spouses, state registered domestic partners, and dependent children" of emergency service personnel who are killed in the line of duty is defined in WAC 182-12-250.

"Dependent care assistance program" or "DCAP" means a benefit plan whereby employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan under chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 129 or other sections of the Internal Revenue Code.

"Director" means the director of the authority.

"Documents" means papers, letters, writings, electronic mail, electronic files, or other printed or written items.

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

"Employee" for the public employees benefits board program includes all employees of the state, whether or not covered by civil service; elected and appointed officials of the executive branch of government, including full-time members of boards, commissions, or committees; justices of the supreme court and judges of the court of appeals and the superior courts; and members of the state legislature. Pursuant to contractual agreement with the authority, "employee" may also include: (a) Employees of a county, municipality, or other political subdivision of the state and members of the legislative authority of any county, city, or town who are elected to office after February 20, 1970, if the legislative authority of the county, municipality, or other political subdivision of the state submits application materials to the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.04.205 and 41.05.021 (1)(g); (b) employees of employee organizations representing state civil service employees, at the option of each such employee organization; (c) through December 31, 2019, employees of a school district or represented employees of an educational service district if the authority agrees to provide any of the school districts' or educational service districts' insurance programs by contract with the authority as provided in RCW 28A.400.350; (d) employees of a tribal government, if the governing body of the tribal government seeks

and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(f) and (g); (e) employees of the Washington health benefit exchange if the governing board of the exchange established in RCW 43.71.020 seeks and receives approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(g) and (n); (f) through December 31, 2019, employees of a charter school established under chapter 28A.710 RCW; and (g) through December 31, 2023, nonrepresented employees of an educational service district. "Employee" does not include: Adult family home providers; unpaid volunteers; patients of state hospitals; inmates; employees of the Washington state convention and trade center as provided in RCW 41.05.110; students of institutions of higher education as determined by their institution; and any others not expressly defined as employees under RCW 41.05.011 or by the authority under this chapter.

"Employer" for the public employees benefits board program means the state of Washington.

"Employer-based group dental" means group dental related to a current employment relationship. It does not include dental coverage available to retired employees, individual market dental coverage, or government-sponsored programs such as medicaid.

"Employer-based group health plan" means group medical and group dental related to a current employment relationship. It does not include medical or dental coverage available to retired employees, individual market medical or dental coverage, or government-sponsored programs such as medicare or medicaid.

"Employer-based group medical" means group medical related to a current employment relationship. It does not include medical coverage available to retired employees, individual market medical coverage, or government-sponsored programs such as medicare or medicaid.

"Employer contribution" means the funding amount paid to the HCA by a state agency or employer group for its eligible employees as described under WAC 182-12-114 and 182-12-131.

"Employer group" means those counties, municipalities, political subdivisions, the Washington health benefit exchange, tribal governments, employee organizations representing state civil service employees, and through December 31, 2019, school districts and charter schools, and through December 31, 2023, educational service districts obtaining employee benefits through a contractual agreement with the authority to participate in benefit plans developed by the public employees benefits board as described in WAC 182-08-245.

"Employer-paid coverage" means PEBB insurance coverage for which an employer contribution is made by a state agency or an employer group for employees eligible in WAC 182-12-114 and 182-12-131. It also means SEBB insurance coverage for which an employer contribution is made by a SEBB organization, or basic benefits described in RCW 28A.400.270(1) for which an employer contribution is made by an educational service district.

"Employing agency" for the public employees benefits board means a division, department, or separate agency of state government, including an institution of higher education; a county, municipality, or other political subdivision; and a tribal government covered by chapter 41.05 RCW.

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

"Exchange" means the Washington health benefit exchange established in RCW 43.71.020, and any other health benefit exchange established under the Affordable Care Act.

"Exchange coverage" means coverage offered by a qualified health plan through an exchange.

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

"Federal retiree medical plan" means the Federal Employees Health Benefits program (FEHB) or TRICARE plans which are not employer-based group medical.

"Forms" or "form" means both paper forms and forms completed electronically.

"Health plan" means a plan offering medical or dental, or both, developed by the ((~~PEBB~~)) board and provided by a contracted vendor or self-insured plans administered by the HCA.

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

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

"Life insurance" means basic life insurance paid for by the employing agency, as well as supplemental life insurance offered to and paid for by employees for themselves and their dependents. Life insurance for eligible retirees includes retiree term life insurance offered to and paid for by retirees.

"Long-term disability insurance" or "LTD insurance" means basic long-term disability insurance paid for by the employing agency and supplemental long-term disability insurance offered to and paid for by the employee.

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby eligible state employees may reduce their salary before taxes to pay for medical expenses not reimbursed by insurance as provided in the salary reduction plan established under chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"Pay status" means all hours for which an employee receives pay.

"PEBB" means the public employees benefits board.

"PEBB benefits" means one or more insurance coverages or other employee benefits administered by the PEBB program within the health care authority.

"PEBB insurance coverage" means any health plan, life insurance, accidental death and dismemberment insurance,

long-term disability (LTD) insurance, long-term care insurance, or property and casualty insurance administered as a PEBB benefit.

"PEBB program" means the program within the HCA that administers insurance and other benefits for eligible employees (as described in WAC 182-12-114), eligible retired employees (as described in WAC 182-12-171 ((~~and~~)), 182-12-180, and 182-12-211), eligible survivors (as described in WAC 182-12-180, 182-12-250, and 182-12-265), eligible dependents (as described in WAC 182-12-250 and 182-12-260) and others as defined in RCW 41.05.011.

"Plan year" means the time period established by the authority.

"Premium payment plan" means a benefit plan whereby public employees may pay their share of group health plan premiums with pretax dollars as provided in the salary reduction plan under chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"Premium surcharge" means a payment required from a subscriber, in addition to the subscriber's medical premium contribution, due to an enrollee's tobacco use or an enrolled subscriber's spouse or state registered domestic partner choosing not to enroll in their employer-based group medical when:

• The spouse's or state registered domestic partner's share of the medical premium is less than ninety-five percent of the additional cost an employee would be required to pay to enroll a spouse or state registered domestic partner in the public employees benefits board (PEBB) Uniform Medical Plan (UMP) Classic; and

• The benefits have an actuarial value of at least ninety-five percent of the actuarial value of PEBB UMP Classic benefits.

"Public employee" has the same meaning as employee.

"Qualified health plan" means a medical plan that is certified to be offered through an exchange.

"Salary reduction plan" means a benefit plan whereby public employees may agree to a reduction of salary on a pretax basis to participate in the dependent care assistance program, medical flexible spending arrangement, or premium payment plan offered pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"School employee" includes:

(a) Through December 31, 2023, all employees of school districts and charter schools established under chapter 28A.710 RCW, and represented employees of educational service districts. For the exclusive purpose of eligibility for PEBB retiree insurance coverage, the term "school employee" also includes nonrepresented employees of an educational service district; and

(b) Effective January 1, 2024, all employees of school districts, educational service districts, and charter schools established under chapter 28A.710 RCW.

"SEBB" means the school employees benefits board ((~~established in RCW 41.05.740~~)).

"SEBB insurance coverage" means any ((~~health plan~~)) medical, dental, vision, life insurance, accidental death and dismemberment insurance, or long-term disability insurance administered as a SEBB benefit.

"SEBB organization" means a public school district or educational service district or charter school established under chapter 28A.710 RCW that is required to participate in benefit plans provided by the school employees benefits board.

"Season" means any recurring annual period of work at a specific time of year that lasts three to eleven consecutive months.

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

"Special open enrollment" means a period of time when subscribers may make changes to their health plan enrollment and salary reduction elections outside of the annual open enrollment period when specific life events occur. During the special open enrollment subscribers may change health plans and enroll or remove dependents from coverage. Additionally, employees may enroll in or waive enrollment in PEBB medical. Employees eligible to participate in the salary reductions plan may enroll in or revoke their election under the DCAP, medical FSA, or the premium payment plan and make a new election. For special open enrollment events related to specific PEBB benefits, see WAC 182-08-198, 182-08-199, 182-12-128, and 182-12-262.

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

"State registered domestic partner" has the same meaning as defined in RCW 26.60.020(1) and substantially equivalent legal unions from other jurisdictions as defined in RCW 26.60.090.

"Subscriber" means the employee, retiree, continuation coverage enrollee, or survivor who has been determined eligible by the PEBB program, employer group, or state agency, is enrolled in PEBB benefits, and is the individual to whom the PEBB program and contracted vendors will issue all notices, information, requests, and premium bills on behalf of an enrollee.

"Supplemental coverage" means any life insurance, accidental death and dismemberment (AD&D) insurance coverage, or long-term disability coverage purchased by the employee in addition to the coverage provided by the employing agency.

"Tobacco products" means any product made with or derived from tobacco that is intended for human consumption, including any component, part, or accessory of a tobacco product. This includes, but is not limited to, cigars, cigarettes, pipe tobacco, chewing tobacco, snuff, and other tobacco products. It does not include e-cigarettes or United States Food and Drug Administration (FDA) approved quit aids.

"Tobacco use" means any use of tobacco products within the past two months. Tobacco use, however, does not include the religious or ceremonial use of tobacco.

"Tribal government" means an Indian tribal government as defined in Section 3(32) of the Employee Retirement

Income Security Act of 1974 (ERISA), as amended, or an agency or instrumentality of the tribal government, that has government offices principally located in this state.

"Waive" means an eligible employee affirmatively declining enrollment in ((~~a PEBB health plan~~)) PEBB medical because the employee is enrolled in other employer-based group medical, a TRICARE plan((~~s~~)), or medicare as allowed under WAC 182-12-128, or is on approved educational leave and obtains another employer-based group health plan as allowed under WAC 182-12-136.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-12-111 Which entities and individuals are eligible for public employees benefits board (PEBB) benefits? The following entities and individuals shall be eligible for public employees benefits board (PEBB) benefits subject to the terms and conditions set forth below:

(1) **State agencies.** State agencies, as defined in WAC 182-12-109, are required to participate in all PEBB benefits. Insurance and health care contributions for ferry employees shall be governed by RCW 47.64.270.

(2) **Employer groups.** Employer groups may apply to participate in PEBB insurance coverage for groups of employees described in (a)(i) of this subsection and for members of the group's governing authority as described in (a)(i), (ii), and (iii) of this subsection at the option of each employer group:

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

(i) Bargaining units may elect to participate separately from the whole group;

(ii) Nonrepresented employees may elect to participate separately from the whole group provided all nonrepresented employees join as a group; and

(iii) Members of the employer group's governing authority may participate as described in the employer group's governing statutes and RCW 41.04.205.

(b) Employer groups must apply through the process described in WAC 182-08-235. Applications from employees of employee organizations representing state civil service employees, the Washington health benefit exchange, and employer groups with five thousand or more employees, except for educational service districts are subject to review and approval by the health care authority (HCA) based on the employer group evaluation criteria described in WAC 182-08-240.

(c) Employer groups participate through a contract with the authority as described in WAC 182-08-245.

(3) **Washington state educational service districts.** In addition to subsection (2) of this section, the following applies to Washington state educational service districts enrolling in PEBB insurance coverage for its nonrepresented employees until December 31, 2023:

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

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

(4) **The Washington health benefit exchange.** In addition to subsection (2) of this section, the following provisions apply:

(a) The Washington health benefit exchange is subject to the same rules as an employing agency in chapters 182-08, 182-12, and 182-16 WAC.

(b) Employees of the Washington health benefit exchange are subject to the same rules as employees of an employing agency in chapters 182-08, 182-12 and 182-16 WAC.

(5) **Eligible nonemployees.**

(a) Blind vendors actively operating a business enterprise program facility in the state of Washington and deemed eligible by the department of services for the blind (DSB) may voluntarily participate in PEBB medical. Dependents of blind vendors are eligible as described in WAC 182-12-260.

(i) Eligible blind vendors and their dependents may enroll during the following times:

(((~~i~~))) • When newly eligible: The DSB will notify eligible blind vendors of their eligibility in advance of the date they are eligible for enrollment in PEBB medical.

To enroll, blind vendors must submit the required forms to the DSB. The forms must be received by the DSB no later than thirty-one days after the blind vendor becomes eligible for PEBB medical((~~.~~));

(((~~ii~~))) • During the annual open enrollment: Blind vendors may enroll during the annual open enrollment. The required form must be received by the DSB before the end of the annual open enrollment. Enrollment will begin January 1st of the following year((~~.~~)); or

(((~~iii~~))) • Following loss of other medical insurance coverage: Blind vendors may enroll following loss of other medical insurance coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA). To enroll, blind vendors must submit the required forms to the DSB. The forms must be received by the DSB no later than sixty days after the loss of other medical insurance coverage. In addition to the required forms, the DSB will require blind vendors to provide evidence of loss of other medical insurance coverage.

(((~~iv~~))) (ii) Blind vendors who cease to actively operate a facility become ineligible to participate in PEBB medical as described in (a) of this subsection. Enrollees who lose eligibility for coverage may continue enrollment in PEBB medical on a self-pay basis under Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage as described in WAC 182-12-146(5).

(((~~v~~))) (iii) Blind vendors are not eligible for PEBB retiree insurance coverage.

(b) Dislocated forest products workers enrolled in the employment and career orientation program pursuant to chapter 50.70 RCW shall be eligible for PEBB ((~~health plans~~)) medical and dental while enrolled in that program.

(c) ((~~School~~)) Board members ((~~or students~~)) of Washington state school districts and educational service districts

eligible to participate under RCW 28A.400.350 may participate in PEBB ((~~insurance coverage~~)) medical, dental, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, supplemental life insurance, and supplemental AD&D insurance as long as they remain eligible under that section. The board of directors must apply through the process described in WAC 182-08-235 and participate through a contract with the HCA as described in WAC 182-08-245. Dependents of board members are eligible as described in WAC 182-12-260.

(i) Upon contract with the HCA, eligible board members may individually decide to enroll in PEBB insurance coverage each plan year. If they elect not to enroll, they may only enroll at the following times:

• During the annual open enrollment; or

• Following loss of other medical insurance coverage as defined by the Health Insurance Portability and Accountability Act (HIPAA).

(ii) Board members who no longer hold a position become ineligible to participate in PEBB insurance coverage as described in (c) of this subsection. Enrollees who lose eligibility for coverage may continue enrollment in PEBB medical, PEBB dental, or both on a self-pay basis under COBRA coverage as described in WAC 182-12-146(6).

(iii) Board members are not eligible for PEBB retiree insurance coverage.

(6) **Individuals and entities not eligible as employees include:**

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

(b) Unpaid volunteers;

(c) Patients of state hospitals;

(d) Inmates in work programs offered by the Washington state department of corrections as described in RCW 72.09.100 or an equivalent program administered by a local government;

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

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

(g) Any others not expressly defined as an employee.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

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

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

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

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

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

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

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

(c) Inform an employee in writing whether or not they are eligible for PEBB benefits upon employment. The written ((~~communication~~)) notice must include a description of any hours that are excluded in determining eligibility and information about the employee's right to appeal eligibility and enrollment decisions. An employee eligible for PEBB benefits must have no less than ten calendar days after the date of notice to elect coverage;

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

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

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

(g) Inform an employee in writing whether or not they are eligible for PEBB benefits and the employer contribution whenever there is a change in work pattern((~~s~~)) such that the employee's eligibility status changes. Whenever this occurs, state agencies must inform the employee of the right to appeal eligibility and enrollment decisions. An employee eligible for PEBB benefits must have no less than ten calendar days after the date of notice to elect coverage.

(3) State agencies must determine employee's dependents eligibility for PEBB ((~~benefits~~)) health plan coverage according to the criteria in WAC 182-12-260.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

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

Hours that are excluded in determining eligibility include standby hours and any temporary increases in work hours, of six months or less, caused by training or emergencies (except governor-declared emergencies) that have not been or are not anticipated to be part of the employee's regular work schedule or pattern. Any hours worked in direct

response to a governor-declared emergency are not excludable and must be included in determining eligibility. In order to include excluded hours in determining eligibility, employing agencies must request and receive the public employees benefits board (PEBB) program's approval ((~~to include temporary training or emergency hours in determining eligibility~~)).

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

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

(a) **Eligibility.** An employee is eligible if they are anticipated to work an average of at least eighty hours per month and are anticipated to work for at least eight hours in each month for more than six consecutive months.

(b) **Determining eligibility.**

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

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

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

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

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

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

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

(d) **When PEBB ((~~insurance coverage~~)) benefits begin((~~s~~)).** Medical, dental, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, ((~~and~~)) basic long-term disability (LTD) insurance, and if eligible, benefits under the salary reduction plan begin on the first day of the month following the date an employee becomes eligible. If the employee becomes eligible on the first working day of a month, then ((~~PEBB insurance~~)) coverage begins on that date. Supplemental life insurance, supplemental AD&D insurance, and supplemental LTD insurance begin on the first day of the month following the date the contracted vendor receives the required form or approves the enrollment.

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

(a) **Eligibility.** A seasonal employee is eligible if they are anticipated to work an average of at least eighty hours per month and are anticipated to work for at least eight hours in each month of at least three consecutive months of the season.

(b) **Determining eligibility.**

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

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

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

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

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

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

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

(d) **When PEBB ((~~insurance coverage~~)) benefits begin((~~s~~)).** Medical, dental, basic life insurance, basic AD&D insurance, ((~~and~~)) basic LTD insurance, and if eligible, benefits under the salary reduction plan begin on the first day of the month following the day the employee becomes eligible. If the employee becomes eligible on the first working day of a month, then ((~~PEBB insurance~~)) coverage begins on that date. Supplemental life insurance, supplemental AD&D insurance, and supplemental LTD insurance begin on the first day of the month following the date the contracted vendor receives the required form or approves the enrollment.

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

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

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

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

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

(b) **Stacking.** Faculty may establish eligibility and maintain the employer contribution toward PEBB ((~~insurance coverage~~)) benefits by working as faculty for more than one institution of higher education. Faculty workloads may only be stacked with other faculty workloads to establish eligibility under this section or maintain eligibility as described in WAC 182-12-131(3). A faculty becomes eligible through stacking when they meet the requirements as described in (a) of this subsection. When a faculty works for more than one institution of higher education, the faculty must notify their employing agencies that they work at more than one institution and may be eligible through stacking.

(c) **When PEBB ((~~insurance coverage~~)) benefits begin((~~s~~)).**

(i) Medical, dental, basic life insurance, basic AD&D insurance, ((~~and~~)) basic LTD insurance, and if eligible, benefits under the salary reduction plan begin on the first day of the month following the day the faculty becomes eligible. If the faculty becomes eligible on the first working day of a month, then ((~~PEBB insurance~~)) coverage begins on that date. Supplemental life insurance, supplemental AD&D insurance, and supplemental LTD insurance begin on the first day of the month following the date the contracted vendor receives the required form or approves the enrollment.

(ii) For faculty hired on a quarter/semester to quarter/semester basis under (a)(ii) of this subsection, medical, dental, basic life insurance, basic AD&D insurance, ((~~and~~)) basic LTD insurance, and if eligible, benefits under the salary reduction plan begin the first day of the month following the beginning of the second consecutive quarter/semester of half-time or more employment. If the first day of the second consecutive quarter/semester is the first working day of the month, then ((~~PEBB insurance~~)) coverage begins at the beginning of the second consecutive quarter/semester. Supplemental life insurance, supplemental AD&D insurance, and supplemental LTD insurance begin on the first day of the month following the date the contracted vendor receives the required form or approves the enrollment.

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

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

(b) **When PEBB ((~~insurance coverage~~)) benefits begin((~~s~~)).** Medical, dental, basic life insurance, basic AD&D insurance, ((~~and~~)) basic LTD insurance, and if eligible, benefits under the salary reduction plan begin on the first day of the month following the day the employee becomes eligible. If the employee becomes eligible on the first working day of a month, then ((~~PEBB insurance~~)) coverage begins on that date. Supplemental life insurance, supplemental AD&D insurance, and supplemental LTD insurance begin on the first day of the month following the date the contracted vendor receives the required form or approves the enrollment.

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

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

(b) **When PEBB ((~~insurance coverage~~)) benefits begin((~~s~~)).** Medical, dental, basic life insurance, basic AD&D insurance, ((~~and~~)) basic LTD insurance, and if eligible, benefits under the salary reduction plan begin on the first day of the month following the day the employee becomes eligible. If the employee becomes eligible on the first working day of a month, then ((~~PEBB insurance~~)) coverage begins on that date. Supplemental life insurance, supplemental AD&D insurance, and supplemental LTD insurance begin on the first day of the month following the date the contracted vendor receives the required form or approves the enrollment.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-12-123 Is dual enrollment in public employees benefits board (PEBB) prohibited? Public employees benefits board (PEBB) ((~~health plan~~)) medical and dental coverage is limited to a single enrollment per individual.

(1) An individual who has more than one source of eligibility for enrollment in PEBB ((~~health plan~~)) medical and dental coverage (called "dual eligibility") is limited to one enrollment.

(2) An eligible employee may waive PEBB medical and enroll as a dependent under the ((~~health~~)) medical plan of their spouse, state registered domestic partner, or parent as described in WAC 182-12-128.

(3) A dependent enrolled in ((~~a PEBB health plan~~)) PEBB medical or dental who becomes eligible for PEBB benefits as an employee must elect to enroll in PEBB benefits as described in WAC 182-08-197 (1) or (3). This includes

making an election to enroll in or waive enrollment in PEBB medical as described in WAC 182-12-128.

(a) If the employee does not waive enrollment in PEBB medical, the employee is not eligible to remain enrolled in their spouse's, state registered domestic partner's, or parent's PEBB ((~~health plan~~)) medical as a dependent. If the employee's spouse, state registered domestic partner, or parent does not remove the employee (who is enrolled as a dependent) from their subscriber account, the PEBB program will terminate the employee's enrollment as a dependent the last day of the month before the employee's enrollment in PEBB benefits begins as described in WAC 182-12-114.

Exception: An enrolled dependent who becomes newly eligible for PEBB benefits as an employee may be dual-enrolled in PEBB ((~~coverage~~)) medical and dental for one month. This exception is only allowed for the first month the dependent is enrolled as an employee, and only if the dependent becomes enrolled as an employee on the first working day of a month that is not the first day of the month.

(b) If the employee elects to waive their enrollment in PEBB medical, the employee will remain enrolled in PEBB medical under their spouse's, state registered domestic partner's, or parent's PEBB ((~~health plan~~)) medical as a dependent.

(4) A child who is eligible for medical and dental under two subscribers may be enrolled ((~~as a dependent under the health plan of only one~~)) under both subscribers but is limited to a single enrollment in PEBB medical and a single enrollment in PEBB dental.

(5) When an employee is eligible for the employer contribution toward((~~s PEBB insurance coverage~~)) PEBB benefits due to employment in more than one PEBB-participating employing agency the following provisions apply:

(a) The employee must choose to enroll under only one employing agency.

Exception: Faculty who stack to establish or maintain eligibility as described in WAC 182-12-114(3) with two or more state institutions of higher education will be enrolled under the employing agency responsible to pay the employer contribution according to WAC 182-08-200(2).

(b) If the employee loses eligibility under the employing agency, they must notify their other employing agency no later than sixty days from the date PEBB ((~~coverage~~)) benefits end((~~s~~)) through the employing agency described in (a) of this subsection to transfer coverage.

(c) The employee's ((~~PEBB insurance coverage~~)) elections remain the same when an employee transfers their enrollment under one employing agency to another employing agency without a break in PEBB ((~~insurance coverage~~)) benefits for one month or more, as described in (b) of this subsection.

(6) A retiree who defers enrollment in ((~~a PEBB health plan~~)) PEBB retiree insurance coverage as described in WAC 182-12-200 by enrolling as an eligible dependent in a health plan sponsored by PEBB, a Washington state educational service district, or SEBB and who loses the employer contribution for such coverage must enroll in PEBB retiree insurance coverage as described in WAC 182-12-200 or defer enrollment as described in WAC 182-12-205.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-12-128 When may an employee waive enrollment in public employees benefits board (PEBB) medical and when may they enroll in PEBB medical after having waived enrollment? An employee may waive enrollment in public employees benefits board (PEBB) medical if they are enrolled in other employer-based group medical, a TRICARE plan, or medicare as described in subsection (1)(a) through (c) of this section. A special open enrollment event must be an event other than an employee gaining initial eligibility for PEBB benefits. An employee who waives enrollment in PEBB medical must enroll in dental, basic life insurance, basic accidental death and dismemberment insurance, and basic long-term disability (LTD) insurance (unless the employing agency does not participate in these PEBB insurance coverages).

(1) To waive enrollment in PEBB medical, the employee must submit the required form to their employing agency at one of the following times:

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

(b) **During the annual open enrollment:** An employee may waive PEBB medical during the annual open enrollment. The required form must be received by the employee's employing agency before the end of the annual open enrollment. PEBB medical will be waived beginning January 1st of the following year.

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

The employee must submit the required form to their employing agency. The employing agency must receive the form no later than sixty days after the event that creates the special open enrollment. In addition to the required form, the employee must provide evidence of the event that creates the special open enrollment to the employing agency.

PEBB medical will be waived the last day of the month following the later of the event date or the date the required form is received. If that day is the first of the month, PEBB medical will be waived the last day of the previous month. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, PEBB medical will be waived the last day of the previous month.

(2) If an employee waives PEBB medical, the employee may not enroll dependents in PEBB medical.

(3) Once PEBB medical is waived, the employee is only allowed to enroll in PEBB medical at the following times:

(a) During the annual open enrollment. The required form must be received by the employee's employing agency before the end of the annual open enrollment. PEBB medical will begin January 1st of the following year.

(b) During a special open enrollment. A special open enrollment allows an employee to revoke their election and make a new election outside of the annual open enrollment. A special open enrollment may be created when one of the events described in subsection (4) of this section occurs.

The employee must submit the required form to their employing agency. The employing agency must receive the form no later than sixty days after the event that creates the special open enrollment. In addition to the required form, the employee must provide evidence of the event that creates the special open enrollment to the employing agency.

PEBB medical will begin the first day of the month following the later of the event date or the date the required form is received. If that day is the first of the month, coverage is effective on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, PEBB medical for the employee will begin ((~~for an employee~~)) on the first day of the month in which the event occurs ((~~(see WAC 182-12-262 for the~~)). PEBB medical ((~~effective date of a~~)) for the newly born child, newly adopted child, spouse, or state registered domestic partner((~~)~~)) will begin as described in WAC 182-12-262 (3)(a)(iv).

(4) **Special open enrollment:** Any one of the events in (a) through (k) of this subsection may create a special open enrollment. The change in enrollment must be allowable under the Internal Revenue Code (IRC) and Treasury regulations, and correspond to and be consistent with the event that creates the special open enrollment for the employee, the employee's dependent, or both.

(a) Employee acquires a new dependent due to:

(i) Marriage or registering a state registered domestic partnership;

(ii) Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or

(iii) A child becoming eligible as an extended dependent through legal custody or legal guardianship.

(b) Employee or an employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);

(c) Employee has a change in employment status that affects the employee's eligibility for their employer contribution toward their employer-based group medical;

(d) The employee's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group medical;

Note: As used in (d) of this subsection, "employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 26 C.F.R. 54.9801-6.

(e) Employee or an employee's dependent has a change in enrollment under an employer-based group medical plan during its annual open enrollment that does not align with the PEBB program's annual open enrollment;

(f) Employee's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States and that change in residence resulted in the dependent losing their health insurance;

(g) A court order requires the employee or any other individual to provide a health plan for an eligible dependent of the employee (a former spouse or former state registered domestic partner is not an eligible dependent);

(h) Employee or an employee's dependent ((~~becomes entitled to~~)) enrolls in coverage under medicaid or a state children's health insurance program (CHIP), or the employee or an employee's dependent loses eligibility for coverage under medicaid or CHIP;

Note: An employee may only return from having waived PEBB medical for the events described in (h) of this subsection. An employee may not waive their PEBB medical for the events described in (h) of this subsection.

(i) Employee or an employee's dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from medicaid or ((~~a state children's health insurance program (CHIP)~~)) CHIP;

(j) Employee or employee's dependent becomes eligible and enrolls in a TRICARE plan, or loses eligibility for a TRICARE plan;

(k) Employee becomes eligible and enrolls in medicare, or loses eligibility for medicare.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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

If an employee moves from an eligible to an otherwise ineligible position due to layoff, the employee may retain their eligibility for the employer contribution toward public employees benefits board (PEBB) ((~~insurance coverage~~)) benefits for each month that the employee is in pay status for at least eight hours. To maintain eligibility using this section the employee must:

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

• Upon hire, notify the employing state agency that they are potentially eligible to use this section.

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

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

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-12-131 How do eligible employees maintain the employer contribution toward public employees benefits board (PEBB) ((~~insurance coverage~~)) benefits? The employer contribution toward public employees benefits board (PEBB) ((~~insurance coverage~~)) benefits begins ((~~on the day that PEBB benefits begin~~)) as described in WAC 182-12-114. This section describes under what circumstances employees maintain eligibility for the employer contribution toward PEBB ((~~insurance coverage~~)) benefits.

(1) **Maintaining the employer contribution.** Except as described in subsections (2), (3), and (4) of this section, employees who have established eligibility for benefits as described in WAC 182-12-114 are eligible for the employer contribution each month in which they are in pay status eight or more hours per month.

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

(a) Benefits-eligible seasonal employees (eligible as described in WAC 182-12-114(2)) who work a season of less than nine months are eligible for the employer contribution in any month of the season in which they are in pay status eight or more hours during that month. The employer contribution toward PEBB ((~~insurance coverage~~)) benefits for seasonal employees returning after their off season begins on the first day of the first month of the season in which they are in pay status eight hours or more.

(b) Benefits-eligible seasonal employees (eligible as described in WAC 182-12-114(2)) who work a season of nine months or more are eligible for the employer contribution:

(i) In any month of the season in which they are in pay status eight or more hours during that month; and

(ii) Through the off season following each season worked, but the eligibility may not exceed a total of twelve consecutive calendar months for the combined season and off season.

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

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

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

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

Exception: Eligibility for the employer contribution toward summer or off-quarter/semester PEBB ((~~insurance coverage~~)) benefits ends on the end date specified in an employing agency's termination notice or an employee's resignation letter, whichever is earlier, if the employing agency has no anticipation that the employee will be returning as faculty at any institution of higher education where the employee has employment. If the employing agency deducted the employee's premium for PEBB insurance coverage after the employee was no longer eligible for the employer contribution, PEBB ((~~insurance coverage~~)) benefits end((~~s~~)) the last day of the month for which employee premiums were deducted.

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

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

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

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

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

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

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

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

(i) Employees on authorized leave without pay;

(ii) Employees on approved educational leave;

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

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

(v) Employees applying for disability retirement.

(5) **Maintaining the employer contribution - Employees who move from an eligible to an otherwise ineligible position due to a layoff** maintain the employer contribution toward PEBB ((~~insurance coverage~~)) benefits as described in WAC 182-12-129.

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

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

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

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

(a) When employees fail to maintain eligibility for the employer contribution as indicated in the criteria in subsections (1) through (6) of this section.

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

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

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

(c) When employees move to a position that is not anticipated to be eligible for PEBB benefits as described in WAC 182-12-114, not including changes in position due to a layoff.

The employer contribution toward PEBB benefits cease for employees and their enrolled dependents the last day of the month in which employees are eligible for the employer contribution under this section.

Exception: If the employing agency deducted the employee's premium for PEBB insurance coverage after the employee was no longer eligible for the employer contribution, PEBB ((~~insurance coverage~~)) benefits end((~~s~~)) the last day of the month for which employee premiums were deducted.

(8) **Options for continuation coverage by self-paying.** During temporary or permanent loss of the employer contribution toward PEBB ((~~insurance coverage~~)) benefits, employees have options for providing continuation coverage for themselves and their dependents by self-paying the premium and applicable premium surcharges set by the health care authority (HCA). These options are available as described in WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, and 182-12-270.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-12-133 What options for continuation coverage are available to employees and their dependents during certain types of leave or when employment ends due to a layoff? Employees who have established eligibility for public employees benefits board (PEBB) benefits as described in WAC 182-12-114 may continue coverage for themselves and their dependents during certain types of leave or when their employment ends due to a layoff.

(1) Employees who are no longer eligible for the employer contribution toward PEBB benefits due to an event described in (b)(i) through (vi) of this subsection may continue ((~~PEBB benefits~~)) coverage by self-paying the premium and applicable premium surcharges set by the health care authority (HCA) from the date eligibility for the employer contribution is lost:

(a) Employees may continue any combination of medical((~~,~~)) or dental, and may also continue life insurance((~~,~~)) and accidental death and dismemberment (AD&D) insurance((~~; however, only~~)). If life insurance or AD&D insurance is elected, both basic life and basic AD&D insurance must be continued. Employees who continue basic life insurance and basic AD&D insurance may also continue supplemental life and AD&D insurance. Employees on approved educational leave or called in to active duty in the uniformed services as defined under the Uniformed Services Employment and Reemployment Rights Act (USERRA) may continue either basic or both basic and supplemental long-term disability (LTD) insurance.

(b) Employees in the following circumstances who lose their eligibility for the employer contribution toward PEBB benefits qualify to continue coverage under this subsection:

(i) Employees who are on authorized leave without pay;

(ii) Employees who are on approved educational leave;

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

(iv) Employees who are called to active duty in the uniformed services as defined under USERRA;

(v) Employees whose employment ends due to a layoff as defined in WAC 182-12-109; and

(vi) Employees who are applying for disability retirement.

(c) The employee's election must be received by the PEBB program no later than sixty days from the date the employee's PEBB health plan coverage ended or from the postmark date on the election notice sent by the PEBB program, whichever is later;

(d) Employees may self-pay for a maximum of twenty-nine months. The employee's first premium payment and applicable premium surcharges are due no later than forty-five days after the election period ends as described in (c) of this subsection.

Premiums and applicable premium surcharges associated with continuing PEBB medical, must be made to the HCA as well as premiums associated with continuing PEBB dental or LTD insurance coverage. Premiums associated with continuing life insurance and AD&D insurance coverage must be made to the contracted vendor. Following the employee's first premium payment, the employee must pay

the premium amounts for PEBB insurance coverage and applicable premium surcharges as premiums become due; and

(e) If the employee's monthly premium or applicable premium surcharges remain unpaid for sixty days from the original due date, the employee's PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharges were paid as described in WAC 182-08-180 (1)(c).

(2) The number of months that employees self-pay the premium while eligible as described in subsection (1) of this section will count toward the total months of continuation coverage allowed under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). Employees who are no longer eligible for continuation coverage as described in subsection (1) of this section but who have not used the maximum number of months allowed under COBRA coverage may continue medical, dental, or both for the remaining difference in months by self-paying the premium and applicable premium surcharges as described in WAC 182-12-146.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-12-138 What options are available if an employee is approved for the federal Family and Medical Leave Act (FMLA) or the paid family and medical leave program? (1) An employee on approved leave under the federal Family and Medical Leave Act (FMLA) ((~~or the family and medical leave insurance program under chapter 50A.04 RCW (paid family and medical leave program)~~)) may continue to receive the employer contribution toward public employees benefits board (PEBB) ((~~insurance coverage~~)) benefits in accordance with the federal FMLA ((~~or RCW 50A.04.245~~)). The employee may also continue current supplemental life, supplemental accidental death and dismemberment (AD&D), and supplemental long-term disability (LTD) insurance. The employee's employing agency is responsible for determining if the employee is eligible for leave under FMLA and the duration of such leave. ((~~The employment security department is responsible for determining if the employee is eligible for leave under the paid family and medical leave program.~~

~~(2) If an employee's monthly premium or applicable premium surcharges remain unpaid for sixty days from the original due date, the employee's PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharges were paid.~~))

(2) An employee on approved leave under the paid family and medical leave program under chapter 50A.05 RCW may continue to receive the employer contribution toward PEBB benefits in accordance with RCW 50A.35.020. The employee may also continue current supplemental life, supplemental AD&D, and supplemental LTD insurance. The employment security department is responsible for determining if the employee is eligible for the paid family and medical leave program.

(3) If an employee exhausts the period of leave approved under FMLA or paid family and medical leave, PEBB insurance coverage may be continued by self-paying the premium and applicable premium surcharges set by the HCA, with no contribution from the employing agency.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-12-141 If an employee reverts from an eligible position, what happens to their public employees benefits board (PEBB) insurance coverage? (1) If an employee reverts for reasons other than a layoff and is not eligible for the employer contribution toward public employees benefits board (PEBB) ((~~insurance coverage~~)) benefits under this chapter, they may continue PEBB insurance coverage by self-paying the premium and applicable premium surcharge set by the health care authority (HCA) for up to eighteen months under the same terms as an employee who is granted leave without pay under WAC 182-12-133(1):

(a) The employee's election must be received by the PEBB program no later than sixty days from the date the employee's PEBB health plan coverage ended or from the postmark date on the election notice sent by the PEBB program, whichever is later;

(b) The employee's first premium payment and applicable premium surcharges are due to the HCA no later than forty-five days after the election period ends as described in (a) of this subsection. Premiums and applicable premium surcharges associated with continuing PEBB medical must be made to the HCA as well as premiums associated with continuing PEBB dental. Premiums associated with continuing life insurance and accidental death and dismemberment insurance coverage must be made to the contracted vendor;

(c) Following the employee's first premium payment, the employee must pay the premium amounts associated with PEBB insurance coverage and applicable premium surcharges as premiums become due; and

(d) If the employee's monthly premium or applicable premium surcharges remain unpaid for sixty days from the original due date, the employee's PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharges were paid as described in WAC 182-08-180 (1)(c).

(2) If an employee is reverted due to a layoff, the employee may be eligible for the employer contribution toward PEBB ((~~insurance coverage~~)) benefits under the criteria of WAC 182-12-129. If determined not to be eligible under WAC 182-12-129, the employee may continue PEBB insurance coverage by self-paying the premium and applicable premium surcharges set by the HCA under WAC 182-12-133.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-12-142 What options for continuation coverage are available to faculty and seasonal employees who are between periods of eligibility? (1) **Faculty** may continue any combination of medical((~~,~~)) or dental, and may also continue life insurance((~~,~~)) and accidental death and dismemberment (AD&D) insurance by self-paying the premium and applicable premium surcharges set by the health care author-

ity (HCA), with no contribution from the employer, for a maximum of twelve months between periods of eligibility. If life insurance or AD&D insurance is elected, both basic life and basic AD&D insurance must be continued. Employees who continue basic life insurance and basic AD&D insurance may also continue supplemental life and AD&D insurance:

(a) The employee's election must be received by the public employees benefits board (PEBB) program no later than sixty days from the date the employee's PEBB health plan coverage ended or from the postmark date on the election notice sent by the PEBB program, whichever is later;

(b) The employee's first premium payment and applicable premium surcharges are due to the HCA no later than forty-five days after the election period ends as described in (a) of this subsection. Premiums and applicable premium surcharges associated with continuing PEBB medical must be made to the HCA as well as premiums associated with continuing PEBB dental. Premiums associated with continuing life insurance and AD&D insurance coverage must be made to the contracted vendor;

(c) Following the employee's first premium payment, the employee must pay the premium amounts associated with PEBB insurance coverage and applicable premium surcharges as premiums become due; and

(d) If the employee's monthly premium or applicable premium surcharges remain unpaid for sixty days from the original due date, the employee's PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharges were paid as described in WAC 182-08-180 (1)(c).

(2) **Benefits-eligible seasonal employees** may continue any combination of medical((,)) or dental, and may also continue life insurance((,)) and AD&D insurance by self-paying the premium and applicable premium surcharges set by the HCA, with no contribution from the employer, for a maximum of twelve months between periods of eligibility. If life insurance or AD&D insurance is elected, both basic life and basic AD&D insurance must be continued. Employees who continue basic life insurance and basic AD&D insurance may also continue supplemental life and AD&D insurance:

(a) The employee's election must be received by the PEBB program no later than sixty days from the date the employee's PEBB health plan coverage ended or from the postmark date on the election notice sent by the PEBB program, whichever is later;

(b) The employee's first premium payment and applicable premium surcharges are due to the HCA no later than forty-five days after the election period ends as described in (a) of this subsection. Premiums and applicable premium surcharges associated with continuing PEBB medical must be made to the HCA as well as premiums associated with continuing PEBB dental. Premiums associated with continuing life insurance and AD&D insurance coverage must be made to the contracted vendor;

(c) Following the employee's first premium payment, the employee must pay the premium amounts associated with PEBB insurance coverage and applicable premium surcharges as premiums become due; and

(d) If the employee's monthly premium or applicable premium surcharges remain unpaid for sixty days from the original due date, the employee's PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharges were paid as described in WAC 182-08-180 (1)(c).

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

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-12-146 When is an enrollee eligible to continue public employees benefits board (PEBB) ((~~health plan coverage~~)) benefits under Consolidated Omnibus Budget Reconciliation Act (COBRA)? (1) An employee or an employee's dependent who loses eligibility for the employer contribution toward public employees benefits board (PEBB) benefits and who qualifies for continuation coverage under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) may continue coverage for PEBB medical, dental, or both.

(2) An employee or an employee's dependent who loses eligibility for continuation coverage described in WAC 182-12-133, 182-12-138, 182-12-141, 182-12-142, or 182-12-148 but who has not used the maximum number of months allowed under COBRA may continue PEBB medical, dental, or both for the remaining difference in months.

(3) A retired employee who loses eligibility for PEBB retiree insurance coverage because an employer group, with the exception of educational service districts, ceases participation in PEBB insurance coverage may continue PEBB medical, dental, or both.

(4) A retiree or a dependent of a retiree, who is no longer eligible as described in WAC 182-12-171, 182-12-180, or 182-12-260 may continue PEBB medical, dental, or both.

(5) A blind vendor who ceases to actively operate a facility as described in WAC 182-12-111 (5)(a) may continue enrollment in PEBB medical for the maximum number of months allowed under COBRA as described in this section.

((~~A blind vendor is not eligible for PEBB retiree insurance coverage.~~))

(6) A board member who no longer qualifies as described in WAC 182-12-111 (5)(c) may continue enrollment in PEBB medical, dental, or both for the maximum number of months allowed under COBRA as described in this section.

(7) An enrollee may continue PEBB ((~~health plan coverage~~)) medical, dental, or both under COBRA by self-paying the premium and applicable premium surcharges set by the health care authority (HCA):

((~~Note:~~ ~~Based on RCW 26.60.015 and public employees benefits board policy resolution that extended PEBB coverage for dependents not otherwise eligible for COBRA, a subscriber's state registered domestic partner and the state registered domestic partner's children may continue PEBB benefits on the same terms and conditions as spouses and other eligible dependents under COBRA.~~))

(a) The election must be received by the PEBB program no later than sixty days from the date the enrollee's PEBB health plan coverage ended or from the postmark date on the election notice sent by the PEBB program, whichever is later;

(b) The first premium payment under COBRA coverage and applicable premium surcharges are due to the HCA no later than forty-five days after the election period ends as described in (a) of this subsection. Following the enrollee's first premium payment, premiums and applicable premium surcharges must be paid as described in WAC 182-08-180 (1)(c);

(c) COBRA continuation coverage enrollees who voluntarily terminate their COBRA coverage will not be eligible to reenroll in COBRA coverage unless they regain eligibility as described in WAC 182-12-114. Those who request to terminate their COBRA coverage must do so in writing. COBRA coverage will end on the last day of the month in which the PEBB program receives the termination request or on the last day of the month specified in the COBRA enrollee's termination request, whichever is later. If the termination request is received on the first day of the month, COBRA coverage will end on the last day of the previous month;

(d) An employee enrolled in a medical flexible spending arrangement (FSA) and the employee's dependents will have an opportunity to continue making contributions to their medical FSA by electing COBRA if on the date of the qualifying event, as described under 42 U.S.C. Sec. 300bb-3, the employee's medical FSA has a greater amount in remaining benefits than remaining contribution payments for the current year. The election must be received by the contracted vendor no later than sixty days from the date the PEBB health plan coverage ended or from the postmark date on the election notice sent by the contracted vendor, whichever is later. The first premium payment under COBRA coverage is due to the contracted vendor no later than forty-five days after the election period ends as described above.

((~~(7)~~)) (8) A subscriber's state registered domestic partner and the state registered domestic partner's children may continue PEBB medical, dental, or both on the same terms and conditions as spouses and other eligible dependents under COBRA as described under RCW 26.60.015.

(9) Medical and dental coverage under COBRA begin on the first day of the month following the day the COBRA enrollee loses eligibility for PEBB health plan coverage as described in WAC 182-12-131, 182-12-133, 182-12-141, 182-12-142, 182-12-148, 182-12-171, 182-12-180, 182-12-250, 182-12-260, or 182-12-265.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-12-148 What options for continuation coverage are available to employees during their appeal of dismissal? (1) Employees awaiting the hearing outcome of a dismissal action before any of the following may continue their public employees benefits board (PEBB) insurance coverage by self-paying the premium and applicable premium surcharges set by the health care authority (HCA), with no contribution from the employer, on the same terms as an employee who is granted leave as described in WAC 182-12-133:

(a) The personnel resources board;

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

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

(d) A court.

(2) The employee must pay premium amounts and applicable premium surcharges associated with PEBB insurance coverage as premiums and applicable premium surcharges become due. If the monthly premium or applicable premium surcharges remain unpaid for sixty days from the original due date, PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharges were paid as described in WAC 182-08-180 (1)(c).

(3) If the dismissal is upheld, all PEBB insurance coverage will ((~~end~~)) terminate at the end of the month in which the decision is entered, or the date to which premiums have been paid, whichever is later, with the exception described in subsection (4) of this section.

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

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

(a) When the employer contribution is reinstated, the HCA will refund to the employee any premiums and applicable premium surcharges the employee paid. In the alternative, at the request of the employee, HCA may deduct the employee's contribution amount for PEBB ((~~insurance coverage~~)) benefits from the refund of premiums and applicable premium surcharges self-paid by the employee during the appeal period.

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

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-12-207 When can a retiree or an eligible dependent's public employees benefits board (PEBB) insurance coverage be terminated by the health care authority (HCA)? A retiree or an eligible dependent's public employees benefits board (PEBB) insurance coverage can be terminated by the health care authority (HCA) for the following reasons:

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

(2) Knowingly providing false information;

(3) Failure to pay the monthly premium or applicable premium surcharges when due as described in WAC 182-08-180 (1)(c);

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

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

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

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-208 What are the requirements regarding enrollment in dental under public employees benefits board (PEBB) retiree insurance coverage? The following provisions apply to a subscriber and their dependents enrolled under public employees benefits board (PEBB) retiree insurance coverage:

(1) A subscriber enrolling in PEBB dental must meet procedural and eligibility requirements under one of the following: WAC 182-12-171, 182-12-180, 182-12-200, 182-12-205, 182-12-211, 182-12-250, 182-12-262, or 182-12-265. The subscriber's dependents must meet eligibility criteria as described in WAC 182-12-250 or 182-12-260.

(2) A subscriber and their dependents must be enrolled in PEBB medical to enroll in PEBB dental. If a subscriber elects to enroll dependents in PEBB dental coverage, the dependents must be enrolled in the same PEBB dental plan as the subscriber.

(3) A subscriber enrolling in PEBB dental must stay enrolled for at least two years before dental can be dropped unless they defer or terminate ((~~medical and dental~~)) PEBB retiree insurance coverage as described in WAC 182-12-200 or 182-12-205, or drop((~~s~~)) dental as described in subsection (4) of this section.

(4) A subscriber enrolled in PEBB dental who becomes eligible for, and enrolls in, employer-based group dental as an employee or the dependent of an employee, or such coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA), or continuation coverage may drop PEBB dental, before completing the two-year enrollment requirement. Coverage will end on the last day of the month in which the required form is received by the PEBB program. If that day is the first of the month, the change in enrollment will be made the last day of the previous month.

(a) A subscriber may enroll, terminate, or change their election in PEBB dental during the PEBB annual open enrollment period. The required form must be received by the PEBB program no later than the last day of the open enrollment period. The change in PEBB dental begins January 1st of the following year.

(b) A subscriber may enroll in PEBB dental after their employer-based group dental or such coverage under COBRA coverage or continuation coverage ends. The required form must be received by the PEBB program no later than sixty days after such coverage ends. PEBB dental begins the first day of the month after the employer-based group dental coverage or continuation coverage under COBRA ends.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-12-209 Who is eligible for retiree term life insurance? Eligible employees who participate in public employees benefits board (PEBB) life insurance as an employee and eligible school employees who participate in school employees benefits board (SEBB) life insurance as an employee and meet qualifications for PEBB retiree insurance coverage as provided in WAC 182-12-171 or 182-12-180, are eligible for retiree term life insurance. They must submit the required forms to the PEBB program. Forms for a retiring employee or a retiring school employee as described in WAC 182-12-171, must be received by the PEBB program no later than sixty days after the date their PEBB or SEBB employee basic life insurance ends. Forms for an official leaving public office as described in WAC 182-12-180, must be received by the PEBB program no later than sixty days after the official leaves public office.

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

(2) Retirees may not defer enrollment in retiree term life insurance, except as allowed in subsection (3)(b) of this section.

(3) If a retiree returns to active employment status and becomes eligible for the employer contribution toward PEBB or SEBB employee basic life insurance, they may choose:

(a) To continue to self-pay premiums and keep retiree term life insurance, the employee or the school employee must pay retiree term life insurance premiums directly to the contracted vendor during the period they are eligible for PEBB or SEBB employee basic life insurance; or

(b) To stop self-paying retiree term life insurance premiums during the period they are eligible for PEBB or SEBB employee basic life insurance and ((~~reelect~~)) elect retiree term life insurance when ((~~they are no longer eligible for the employer contribution toward~~)) PEBB or SEBB employee basic life insurance ends.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-250 Public employees benefits board (PEBB) insurance coverage eligibility for survivors of emergency service personnel killed in the line of duty. Surviving spouses, state registered domestic partners, and dependent children of emergency service personnel who are killed in the line of duty are eligible to enroll or defer enrollment in public employees benefits board (PEBB) retiree insurance coverage.

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

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

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

(a) A lawful spouse;

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

(c) A state registered domestic partner as defined in RCW 26.60.020(1); and

(d) Children. The term "children" includes children of the emergency service worker up to age twenty-six. Children with disabilities as defined in RCW 41.26.030(6) are eligible at any age. "Children" is defined as:

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

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

(iii) Legally adopted children;

(iv) Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child;

(v) Children specified in a court order or divorce decree; or

(vi) Children as defined in RCW 26.26A.100.

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

Note: For the exclusive purpose of medicare Part A as described in this subsection, "eligible" means the enrollee is eligible for medicare Part A without a monthly premium.

(5) The survivor (or agent acting on their behalf) must submit the required forms to the PEBB program to either enroll or defer enrollment in PEBB retiree insurance coverage as described in subsection (7) of this section. The forms must be received by the PEBB program no later than one hundred eighty days after the later of:

(a) The death of the emergency service worker;

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

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

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

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

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

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

(c) The first of the month after the date that the PEBB program receives the required forms.

Exception: Enrollment in the PEBB program's medicare advantage or medicare advantage-prescription drug plan may not be retroactive. If the forms are received after the date enrollment in PEBB retiree insurance coverage is to begin, the survivor may not select a medicare advantage or medicare advantage-prescription drug plan until a special enrollment period as described in WAC 182-08-198(2).

For surviving spouses, state registered domestic partners, and children who enroll, monthly health plan premiums and applicable premium surcharges must be paid by the survivor as described in WAC 182-08-180 (1)(c) except as provided in RCW 41.26.510(5) and 43.43.285 (2)(b).

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

(a) Enroll in a PEBB health plan:

(i) Enroll in medical; or

(ii) Enroll in medical and dental.

(iii) Survivors enrolling in dental must stay enrolled for at least two years before dental can be dropped, unless they defer ((~~medical and dental~~)) PEBB retiree insurance coverage as described in WAC 182-12-205, or drop dental as described in WAC 182-12-208(4).

(iv) Dental only is not an option.

(b) Defer enrollment:

(i) Survivors may defer enrollment in ((~~a PEBB health plan~~)) PEBB retiree insurance coverage if continuously enrolled in qualifying coverage as described in WAC 182-12-205(3).

(ii) Survivors may enroll in a PEBB health plan as described in WAC 182-12-205(6) when they lose other cov-

erage. Survivors must provide evidence that they were continuously enrolled in one or more qualifying coverages as described in WAC 182-12-205 (3)(a) through (e) when enrolling in a PEBB health plan. The required form and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after such coverage ends.

Exception: Enrollment in the PEBB program's medicare advantage or medicare advantage-prescription drug plan may not be retroactive so the required forms and evidence of continuous enrollment must be received by the PEBB program no later than the last day of the month prior to the month coverage ends. If the forms are received after the date enrollment in PEBB retiree insurance coverage is to begin, the survivor may not select a medicare advantage or medicare advantage-prescription drug plan until a special enrollment period as described in WAC 182-08-198(2).

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

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

(9) Survivors will lose their right to enroll in PEBB retiree insurance coverage if they:

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

(b) Do not maintain continuous enrollment in other qualifying coverage during the deferral period, as described in subsection (7)(b)(i) of this section.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

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

The public employees benefits board (PEBB) program verifies the eligibility of all dependents and will request documents from subscribers that provide evidence of a dependent's eligibility. The PEBB program reserves the right to review a dependent's eligibility at any time. The PEBB program will remove a subscriber's enrolled dependents from health plan ((~~enrollment~~)) coverage if the PEBB program is unable to verify a dependent's eligibility. ((~~The PEBB program will not enroll dependents into PEBB benefits~~)) A dependent will not be enrolled in PEBB health plan coverage if the PEBB program or the employing agency is unable to verify ((~~a~~)) the dependent's eligibility within the PEBB program enrollment timelines.

The subscriber must provide notice, in writing, when their dependent is not eligible under this section as described in WAC 182-12-262 (2)(a).

The following are eligible as dependents:

(1) Legal spouse. A former spouse is not an eligible dependent upon finalization of a divorce or annulment, even if a court order requires the subscriber to provide health insurance for the former spouse;

(2) State registered domestic partner. A former state registered domestic partner is not an eligible dependent upon dissolution or termination of a partnership, even if a court order requires the subscriber to provide health insurance for the former partner;

(3) Children. Children are eligible through the last day of the month in which their twenty-sixth birthday occurred except as described in (g) of this subsection. Children are defined as the subscriber's:

(a) Children based on establishment of a parent-child relationship as described in RCW 26.26A.100, except when parental rights have been terminated;

(b) Children of the subscriber's spouse, based on the spouse's establishment of a parent-child relationship, except when parental rights have been terminated. The stepchild's relationship to the subscriber (and eligibility as a dependent) ends on the same date the marriage with the spouse ends through divorce, annulment, dissolution, termination, or death;

(c) Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child;

(d) Children of the subscriber's state registered domestic partner, based on the state registered domestic partner's establishment of a parent-child relationship, except when parental rights have been terminated. The child's relationship to the subscriber (and eligibility as a dependent) ends on the same date the subscriber's legal relationship with the state registered domestic partner ends through divorce, annulment, dissolution, termination, or death;

(e) Children specified in a court order or divorce decree for whom the subscriber has a legal obligation to provide support or health care coverage;

(f) Extended dependent in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or subscriber's state registered domestic partner. The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. Extended dependent child does not include a foster child unless the subscriber, the subscriber's spouse, or the subscriber's state registered domestic partner has assumed a legal obligation for total or partial support in anticipation of adoption; and

(g) Children of any age with a developmental or physical disability that renders the child incapable of self-sustaining employment and chiefly dependent upon the subscriber for support and maintenance provided such condition occurs before the age of twenty-six:

(i) The subscriber must provide proof of the disability and dependency within sixty days of the child's attainment of age twenty-six;

(ii) The subscriber must notify the PEBB program, in writing, when the child is no longer eligible under this subsection as described in WAC 182-12-262 (2)(a);

(iii) A child with a developmental or physical disability who becomes self-supporting is not eligible under this sub-

section as of the last day of the month in which they become capable of self-support;

(iv) A child with a developmental or physical disability age twenty-six and older who becomes capable of self-support does not regain eligibility ((~~under (i) of this subsection~~)) if they later become incapable of self-support; and

(v) The PEBB program with input from the applicable contracted vendor will periodically verify the eligibility of a dependent child with a disability beginning at age twenty-six, but no more frequently than annually after the two-year period following the child's twenty-sixth birthday((~~, which may~~)). Verification will require renewed proof of disability and dependence from the subscriber.

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

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

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

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

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

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

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

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-12-262 When may subscribers enroll or remove eligible dependents? (1) **Enrolling dependents in public employees benefits board (PEBB) ((~~benefits~~)) health plan coverage and the effective date of supplemental dependent life insurance and accidental death and dismemberment (AD&D) insurance.** A dependent must be enrolled in the same health plan coverage as the subscriber, and the subscriber must be enrolled to enroll their dependent except as provided in WAC 182-12-205 (3)(c). Subscribers must satisfy the enrollment requirements as described in subsection (4) of this section and may enroll eligible dependents at the following times:

(a) **When the subscriber becomes eligible** and enrolls in PEBB benefits. If eligibility is verified ((~~and the dependent is enrolled,~~)) the dependent's effective date will be as follows:

(i) PEBB health plan coverage will be the same as the subscriber's effective date((~~, except if the subscriber enrolls a newborn child in supplemental dependent life insurance and accidental death and dismemberment (AD&D) insurance. The newborn child's dependent life insurance and AD&D insurance coverage will be effective on the date the child becomes fourteen days old~~));

(ii) Supplemental dependent life or AD&D insurance, if elected, will be effective the first day of the month following the date the contracted vendor receives the required form or approves the enrollment. A newly born child must be at least fourteen days old before supplemental dependent life insurance or AD&D insurance coverage is effective.

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

(c) **During special open enrollment.** Subscribers may enroll dependents during a special open enrollment as described in subsection (3) of this section;

(d) **When a National Medical Support Notice (NMSN)** requires a subscriber to cover a dependent child as described in WAC 182-12-263; or

(e) **Any time during the calendar year for supplemental dependent life insurance or AD&D insurance** by submitting the required form to the contracted vendor for approval. Evidence of insurability may be required for supplemental dependent life insurance but will not be required for supplemental AD&D insurance.

(2) **Removing dependents from a subscriber's PEBB health plan coverage or supplemental dependent life insurance or AD&D insurance.**

(a) **A dependent's eligibility for enrollment in PEBB health plan coverage or supplemental dependent life insurance or AD&D insurance ends the last day of the month the dependent** meets the eligibility criteria as described in WAC 182-12-250 or 182-12-260. Subscribers must provide notice when a dependent is no longer eligible due to divorce, annulment, dissolution, or qualifying event of a dependent ceasing to be eligible as a dependent child, as described in WAC 182-12-260(3). The notice must be received within sixty days of the last day of the month the dependent loses eligibility for PEBB health plan coverage. Employees must notify their employing agency when a dependent is no longer eligible, except as required under WAC 182-12-260 (3)(g)(ii). All other subscribers must notify the PEBB program. Consequences for not submitting notice within the required sixty days include, but are not limited to:

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

(ii) The subscriber may be billed for claims paid by the health plan for services that were rendered after the dependent lost eligibility as described in WAC 182-12-270;

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

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

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

(i) During the annual open enrollment. The dependent will be removed from PEBB health plan coverage the last day of December; ((~~or~~))

(ii) During a special open enrollment as described in subsections (3) and (4)(f) of this section;

(iii) When a NMSN requires a spouse, former spouse, or other individual to provide health plan coverage for a dependent who is already enrolled in PEBB coverage, and that health plan coverage is in fact provided as described in WAC 182-12-263(2); or

(iv) Any time during the calendar year from supplemental dependent life or AD&D insurance by submitting the required form to the contracted vendor.

(c) **Retirees (see WAC 182-12-171, 182-12-180, or 182-12-211), survivors (see WAC 182-12-180, 182-12-250, or 182-12-265), and PEBB continuation coverage enrollees (see WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, or 182-12-148) may remove dependents** from their PEBB ((~~insurance coverage~~)) health plan coverage outside of the annual open enrollment or a special open enrollment by providing written notice to the PEBB program. The dependent will be removed from the subscriber's PEBB ((~~insurance~~)) health plan coverage prospectively. PEBB ((~~insurance~~)) health plan coverage will end on the last day of the month in which the written notice is received by the PEBB program or on the last day of the month specified in the subscriber's written notice, whichever is later. If the written notice is received on the first day of the month, PEBB health plan coverage will end on the last day of the previous month. PEBB continuation coverage enrollees may remove supplemental dependent life or AD&D insurance any time during the calendar year by submitting the required form to the contracted vendor.

(3) **Special open enrollment.**

(a) Subscribers may enroll or remove their eligible dependents outside of the annual open enrollment if a special open enrollment event occurs. The change in enrollment must be allowable under the Internal Revenue Code and Treasury Regulations, and correspond to and be consistent with the event that creates the special open enrollment for the subscriber, the subscriber's dependents, or both. To disenroll from a medicare advantage or medicare advantage-prescription drug plan, the change in enrollment must be allowable under 42 C.F.R. Sec. 422.62(b) and 42 C.F.R. Sec. 423.38(c).

(i) PEBB ((~~benefits~~)) health plan coverage will begin the first of the month following the later of the event date or the date the required form is received. If that day is the first of the month, the change in enrollment begins on that day.

(ii) ((~~Enrollment of~~)) PEBB health plan coverage for an extended dependent or a dependent with a disability will ((~~be~~)) begin the first day of the month following the later of the event date ((~~as described in WAC 182-08-198(2)~~)) or eligibility certification.

(iii) The dependent will be removed from the subscriber's PEBB health plan coverage the last day of the month following the later of the event date or the date the required form and proof of the event is received. If that day is the first of the month, the change in enrollment will be made the last day of the previous month.

(iv) If the special open enrollment is due to the birth or adoption of a child, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of a child, PEBB ((~~benefits~~)) health plan coverage will begin or end as follows:

• For the newly born child, PEBB ((~~benefits~~)) health plan coverage will begin the date of birth;

• For a newly adopted child, PEBB ((~~benefits~~)) health plan coverage will begin on the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier;

• For a spouse or state registered domestic partner of a subscriber, PEBB ((~~benefits~~)) health plan coverage will begin the first day of the month in which the event occurs. The spouse or state registered domestic partner will be removed from PEBB health plan coverage the last day of the month in which the event occurred;

((~~A newly born child must be at least fourteen days old before supplemental dependent life insurance and AD&D insurance coverage purchased by the employee becomes effective.~~))

(b) Any one of the following events may create a special open enrollment:

((~~(b)~~)) (i) Subscriber acquires a new dependent due to:

((~~(i)~~)) • Marriage or registering a state registered domestic partnership;

((~~(ii)~~)) • Birth, adoption, or when a subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or

((~~(iii)~~)) • A child becoming eligible as an extended dependent through legal custody or legal guardianship.

((~~(c)~~)) (ii) Subscriber or a subscriber's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);

((~~(d)~~)) (iii) Subscriber has a change in employment status that affects the subscriber's eligibility for their employer contribution toward their employer-based group health plan;

((~~(e)~~)) (iv) The subscriber's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan;

Note: As used in ((~~(e)~~)) (iv) of this subsection, "employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 54.9801-6.

((~~(f)~~)) (v) Subscriber or a subscriber's dependent has a change in enrollment under an employer-based group health plan during its annual open enrollment that does not align with the PEBB program's annual open enrollment;

((~~(g)~~)) (vi) Subscriber's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States and that change in residence resulted in the dependent losing their health insurance;

((~~(h)~~)) (vii) A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state registered domestic partner is not an eligible dependent);

((~~(i)~~)) (viii) Subscriber or a subscriber's dependent ((~~becomes entitled to~~)) enrolls in coverage under medicaid or a state children's health insurance program (CHIP), or the subscriber or a subscriber's dependent loses eligibility for coverage under medicaid or CHIP;

((~~(j)~~)) (ix) Subscriber or a subscriber's dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from medicaid or CHIP.

(4) **Enrollment requirements. A subscriber must submit the required forms within the time frames described in this subsection.** For PEBB health plan coverage, an employee must submit the required forms to their employing

agency, a subscriber on continuation coverage or PEBB retiree insurance coverage must submit the required forms to the PEBB program. In addition to the required forms indicating dependent enrollment, the subscriber must provide the required documents as evidence of the dependent's eligibility; or as evidence of the event that created the special open enrollment. All required forms and documents must be received within the required time frames. An employee enrolling a dependent in supplemental life insurance or AD&D insurance must submit the required form to the contracted vendor for approval within the required time frames.

(a) If a subscriber wants to enroll their eligible dependents in PEBB health plan coverage when the subscriber becomes eligible to enroll in PEBB benefits, the subscriber must include the dependent's enrollment information on the required forms and submit them within the required time frame described in WAC 182-08-197, 182-08-187, 182-12-171, 182-12-180, 182-12-211, or 182-12-250. If an employee enrolls a dependent in supplemental life insurance or AD&D insurance, the required form must be submitted within the required time frame described in WAC 182-08-197 or 182-08-187.

(b) If a subscriber wants to enroll eligible dependents in PEBB health plan coverage during the PEBB annual open enrollment period, the required forms must be received no later than the last day of the annual open enrollment.

(c) If a subscriber wants to enroll newly eligible dependents, the required forms must be received no later than sixty days after the dependent becomes eligible. An employee enrolling a dependent in supplemental life insurance or AD&D insurance must submit the required form to the contracted vendor for approval. An employee may enroll a dependent in supplemental life insurance up to the guaranteed issue coverage amount without evidence of insurability if the required form is submitted to the contracted vendor as required. Evidence of insurability will be required for supplemental dependent life insurance over the guaranteed issue coverage amount. Evidence of insurability is not required for supplemental AD&D insurance.

(d) If a subscriber wants to enroll a newborn or child whom the subscriber has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption in PEBB health plan coverage, the subscriber should notify the PEBB program by submitting the required forms as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the required forms must be received no later than sixty days after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption. An employee enrolling a dependent in supplemental life insurance or AD&D insurance must submit the required form to the contracted vendor for approval. A newly born child must be at least fourteen days old before supplemental dependent life insurance or AD&D insurance coverage can become effective.

(e) If the subscriber wants to enroll a child age twenty-six or older as a child with a disability in PEBB health plan coverage, the required forms must be received no later than sixty days after the ((~~last day of the month in which the~~)) child reaches age twenty-six or within the relevant time frame described in ((~~WAC 182-12-262 (4)~~))(a), (b), and (f) of this subsection. To recertify an enrolled child with a disability, the required forms must be received by the PEBB program or the contracted vendor by the child's scheduled PEBB health plan coverage termination date.

(f) If the subscriber wants to change a dependent's enrollment status in PEBB health plan coverage during a special open enrollment, the required forms must be received no later than sixty days after the event that creates the special open enrollment.

Exception: If the subscriber wants to change a dependent's enrollment or disenrollment in a medicare advantage or medicare advantage-prescription drug plan, the required forms must be received during a special enrollment period as allowed under 42 C.F.R. Sec. 422.62(b) and 42 C.F.R. Sec. 423.38(c).

(g) An employee may enroll a dependent in supplemental life insurance or AD&D insurance at any time during the calendar year by submitting the required form to the contracted vendor for approval. Evidence of insurability may be required for supplemental dependent life insurance but will not be required for supplemental AD&D insurance.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-12-263 National Medical Support Notice (NMSN). (1) When a National Medical Support Notice (NMSN) requires a subscriber to provide health plan coverage for a dependent child the following provisions apply:

(a) The subscriber may enroll their dependent child and request changes to their health plan coverage as described under subsection (c) of this section. Employees submit the required forms to their employing agency. Subscribers on continuation coverage or PEBB retiree insurance coverage submit the required forms to the public employees benefits board (PEBB) program.

(b) If the subscriber fails to request enrollment or health plan coverage changes as directed by the NMSN, the employing agency or the PEBB program may make enrollment or health plan coverage changes according to (c) of this subsection upon request of:

(i) The child's other parent; or

(ii) Child support enforcement program.

(c) Changes to health plan coverage or enrollment are allowed as directed by the NMSN:

(i) The dependent will be enrolled under the subscriber's health plan coverage as directed by the NMSN;

(ii) An employee who has waived PEBB medical under WAC 182-12-128 will be enrolled in medical as directed by the NMSN, in order to enroll the dependent;

(iii) The subscriber's selected health plan will be changed if directed by the NMSN;

(iv) If the dependent is already enrolled under another PEBB subscriber, the dependent will be removed from the other health plan coverage and enrolled as directed by the NMSN; or

(v) If the subscriber is eligible for and elects Consolidated Omnibus Budget Reconciliation Act (COBRA) or other continuation coverage, the NMSN will be enforced and

the dependent must be covered in accordance with the NMSN.

(d) Changes to health plan coverage or enrollment as described in (c)(i) through (iii) of this subsection will begin the first day of the month following receipt by the employing agency of the NMSN. If the NMSN is received by the employing agency on the first day of the month, the change to health plan coverage or enrollment begins on that day. A dependent will be removed from the subscriber's health plan coverage as described in (c)(iv) of this subsection the last day of the month the NMSN is received. If that day is the first of the month, the change in enrollment will be made the last day of the previous month.

(2) When a NMSN requires a spouse, former spouse, or other individual to provide health plan coverage for a dependent who is already enrolled in PEBB coverage, and that health plan coverage is in fact provided, the dependent may be removed from the subscriber's PEBB ((~~insurance~~)) health plan coverage prospectively.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-12-270 What options for continuation coverage are available to dependents who cease to meet the eligibility criteria as described in WAC 182-12-260? If eligible, dependents may continue health plan enrollment under one of the continuation coverage options in subsection (1) or (2) of this section by self-paying the premiums and applicable premium surcharges set by the health care authority (HCA), with no contribution from the employer, following their loss of eligibility under the subscriber's health plan coverage. The dependent's first premium payment and applicable premium surcharges are due ((~~to the HCA~~)) no later than forty-five days after the election period ends as described in WAC 182-12-146, 182-12-180, 182-12-250, or 182-12-265, whichever applies. Premiums and applicable premium surcharges associated with continuing PEBB medical, must be made to the HCA as well as premiums associated with continuing PEBB dental insurance coverage. Following the dependent's first premium payment, the dependent must pay premium and applicable premium ((~~surcharge amounts associated with PEBB insurance coverage as premiums and applicable premium~~)) surcharges as they become due. If the monthly premium or applicable premium surcharges remain unpaid for sixty days from the original due date, PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharges were paid as described in WAC 182-08-180 (1)(c). The PEBB program must receive the required forms as outlined in the *PEBB Initial Notice of COBRA and Continuation Coverage Rights*. Options for continuing health plan enrollment are based on the reason that eligibility was lost.

(1) Spouses, state registered domestic partners, or children who lose eligibility due to the death of an employee or retiree may be eligible to continue health plan enrollment as described in WAC 182-12-180, 182-12-250, or 182-12-265; or

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

((~~**Note:** Based on RCW 26.60.015 and public employees benefits board policy resolution that extended PEBB coverage for dependents not otherwise eligible for COBRA, a subscriber's state registered domestic partner and the state registered partner's children may continue PEBB insurance coverage on the same terms and conditions as spouses and other eligible dependents under COBRA.~~))

(3) A subscriber's state registered domestic partner and the state registered domestic partner's children may continue PEBB medical, dental, or both on the same terms and conditions as spouses and other eligible dependents under COBRA as described under RCW 26.60.015.

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

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-12-300 Public employees benefits board (PEBB) wellness incentive program eligibility and procedural requirements. The ((~~public employees benefits board (PEBB)~~)) board annually determines the design of the PEBB wellness incentive program.

(1) All subscribers, except PEBB subscribers who are enrolled in both medicare Parts A and B, and in the medicare risk pool as described in RCW 41.05.080(3), are eligible to participate in the PEBB wellness incentive program.

(2) Effective January 1, 2020, to receive the PEBB wellness incentive of a reduction to the subscriber's medical plan deductible or a deposit to the subscriber's health savings account for the following plan year, eligible subscribers must complete PEBB wellness incentive program requirements during the current plan year by the following deadline:

(a) For subscribers continuing enrollment in PEBB medical and subscribers enrolling in PEBB medical with an effective date in January through September, the deadline is November 30th; or

(b) For subscribers enrolling in PEBB medical with an effective date in October through December, the deadline is December 31st.

(3) Subscribers who do not complete the requirements according to subsection (2) of this section, except as noted, within the time frame described are not eligible to receive a PEBB wellness incentive the following plan year.

Note: All eligible subscribers can earn a wellness incentive. Subscribers who cannot complete the wellness incentive program requirements may be able to earn the same incentive by different means. The contracted vendor will work with enrollees (and their physician, if they wish) to define an individual wellness program that provides the opportunity to qualify for the same incentive in light of the enrollee's health status.

(4) Effective January 1, 2018, an eligible subscriber will receive a separate PEBB wellness incentive for completing the SmartHealth well-being assessment on or before December 31st, of the current plan year. An eligible subscriber may only earn this separate PEBB wellness incentive once per plan year. Once earned, subscribers must claim the incentive on or before December 31st of the same calendar year it was earned.

(5) A PEBB wellness incentive will be provided only if:

(a) For the wellness incentive described in subsection (2) of this section the subscriber is still eligible for the PEBB wellness incentive program and is enrolled in a PEBB medical plan in the year the incentive applies;

(b) The funding rate provided by the legislature is designed to provide a PEBB wellness incentive program or a PEBB wellness incentive, or both; or

(c) Specific appropriations are provided for wellness incentives.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-020 Definitions. The following definitions apply throughout this chapter unless the context clearly indicates another meaning:

"Accidental death and dismemberment insurance" or "AD&D" means basic accidental death and dismemberment (AD&D) insurance paid for by the employing agency, as well as supplemental accidental death and dismemberment insurance offered to and paid for by employees for themselves and their dependents.

"Appellant" means a person who requests a brief adjudicative proceeding with the PEBB appeals unit about the action of the employing agency, the HCA, or its contracted vendor.

"Authority" or "HCA" means the Washington state health care authority.

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

"Brief adjudicative proceeding" means the process described in RCW 34.05.482 through 34.05.494 and in WAC 182-16-2000 through 182-16-2160.

"Business days" means all days except Saturdays, Sundays, and all state legal holidays as set forth in RCW 1.16.050.

"Calendar days" or "days" means all days including Saturdays, Sundays, and all ((~~legal~~)) state legal holidays as set forth in RCW 1.16.050.

"Continuance" means a change in the date or time of when a brief adjudicative proceeding or formal administrative hearing will occur.

"Contracted vendor" means any person, persons, or entity under contract or agreement with the HCA to provide goods or services for the provision or administration of PEBB benefits. The term "contracted vendor" includes subcontractors of the HCA and subcontractors of any person, persons, or entity under contract or agreement with the HCA that provide goods or services for the provision or administration of PEBB benefits.

"Denial" or "denial notice" means an action by, or communication from, an employing agency, contracted vendor, or the PEBB program that aggrieves a subscriber, a dependent, or an applicant, with regard to PEBB benefits including, but not limited to, actions or communications expressly designated as a "denial," "denial notice," or "cancellation notice."

"Dependent" means a person who meets eligibility requirements in WAC 182-12-260, except that "surviving spouses, state registered domestic partners, and dependent children" of emergency service personnel who are killed in the line of duty is defined in WAC 182-12-250.

"Dependent care assistance program" or "DCAP" means a benefit plan whereby state employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan under chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 129 or other sections of the Internal Revenue Code.

"Director" means the director of the authority.

"Dispositive motion" means a motion made to a presiding officer, review officer, or hearing officer to decide a claim or case in favor of the moving party without further proceedings.

"Documents" means papers, letters, writings, electronic mail, electronic files, or other printed or written items.

"Employee" for the public employees benefits board program includes all employees of the state, whether or not covered by civil service; elected and appointed officials of the executive branch of government, including full-time members of boards, commissions, or committees; justices of the supreme court and judges of the court of appeals and the superior courts; and members of the state legislature. Pursuant to contractual agreement with the authority, "employee" may also include: (a) Employees of a county, municipality, or other political subdivision of the state and members of the legislative authority of any county, city, or town who are elected to office after February 20, 1970, if the legislative authority of the county, municipality, or other political subdivision of the state submits application materials to the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.04.205 and 41.05.021 (1)(g); (b) employees of employee organizations representing state civil service employees, at the option of each such employee organization; (c) through December 31, 2019, employees of a school district or represented employees of an educational service district if the authority agrees to provide any of the school districts' or educational service districts' insurance programs by contract with the authority as provided in RCW 28A.400.350; (d) employees of a tribal government, if the governing body of the tribal government seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(f) and (g); (e) employees of the Washington health benefit exchange if the governing board of the exchange established in RCW 43.71.020 seeks and receives approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(g) and (n); (f) through December 31, 2019, employees of a charter school established under chapter 28A.710 RCW; and (g) through December 31, 2023, non-

represented employees of an educational service district. "Employee" does not include: Adult family home providers; unpaid volunteers; patients of state hospitals; inmates; employees of the Washington state convention and trade center as provided in RCW 41.05.110; students of institutions of higher education as determined by their institution; and any others not expressly defined as employees under RCW 41.05.011 or by the authority under this chapter.

"Employer-based group medical" means group medical related to a current employment relationship. It does not include medical coverage available to retired employees, individual market medical coverage, or government-sponsored programs such as medicare or medicaid.

"Employer group" means those counties, municipalities, political subdivisions, the Washington health benefit exchange, tribal governments, employee organizations representing state civil service employees, and through December 31, 2019, school districts and charter schools, and through December 31, 2023, educational service districts obtaining employee benefits through a contractual agreement with the authority to participate in benefit plans developed by the public employees benefits board as described in WAC 182-08-245.

"Employing agency" for the public employees benefits board program means a division, department, or separate agency of state government, including an institution of higher education; a county, municipality, or other political subdivision; and a tribal government covered by chapter 41.05 RCW.

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

"File" or "filing" means the act of delivering documents to the office of the presiding officer, review officer, or hearing officer. A document is considered filed when it is received by the authority or its designee.

"Final order" means an order that is the final health care authority decision.

"Formal administrative hearing" means a proceeding before a hearing officer that gives an appellant an opportunity for an evidentiary hearing as described in RCW 34.05.413 through 34.05.476 and WAC 182-16-3000 through 182-16-3200.

"HCA hearing representative" means a person who is authorized to represent the PEBB program in a formal administrative hearing. The person may be an assistant attorney general or authorized HCA employee.

"Health plan" means a plan offering medical or dental, or both, developed by the ((~~PEBB~~)) board and provided by a contracted vendor or self-insured plans administered by the HCA.

"Hearing officer" means an impartial decision maker who presides at a formal administrative hearing, and is:

• A director-designated HCA employee; or

• When the director has designated the office of administrative hearings (OAH) as a hearing body, an administrative law judge employed by the OAH.

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

"Life insurance" means basic life insurance paid for by the employing agency, as well as supplemental life insurance offered to and paid for by employees for themselves and their dependents. Life insurance for eligible retirees includes retiree term life insurance offered to and paid for by retirees.

"Long-term disability insurance" or "LTD insurance" means basic long-term disability insurance paid for by the employing agency and supplemental long-term disability insurance offered to and paid for by the employee.

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby eligible state employees may reduce their salary before taxes to pay for medical expenses not reimbursed by insurance as provided in the salary reduction plan established under chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"PEBB" means the public employees benefits board.

"PEBB benefits" means one or more insurance coverages or other employee benefits administered by the PEBB program within the health care authority.

"PEBB insurance coverage" means any health plan, life insurance, accidental death and dismemberment insurance, long-term disability (LTD) insurance, long-term care insurance, or property and casualty insurance administered as a PEBB benefit.

"PEBB program" means the program within the HCA that administers insurance and other benefits for eligible employees (as described in WAC 182-12-114), eligible retired employees (as described in WAC 182-12-171 ((~~and~~)), 182-12-180, and 182-12-211), eligible survivors (as described in WAC 182-12-180, 182-12-250, and 182-12-265), eligible dependents (as described in WAC 182-12-250 and 182-12-260), and others as defined in RCW 41.05.011.

"Prehearing conference" means a proceeding scheduled and conducted by a hearing officer to address issues in preparation for a formal administrative hearing.

"Premium payment plan" means a benefit plan whereby public employees may pay their share of group health plan premiums with pretax dollars as provided in the salary reduction plan under chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"Premium surcharge" means a payment required from a subscriber, in addition to the subscriber's medical premium contribution, due to an enrollee's tobacco use or an enrolled subscriber's spouse or state registered domestic partner choosing not to enroll in their employer-based group medical when:

• The spouse's or state registered domestic partner's share of the medical premiums is less than ninety-five percent of the additional cost an employee would be required to pay to enroll a spouse or state registered domestic partner in the public employees benefits board (PEBB) Uniform Medical Plan (UMP) Classic; and

• The benefits have an actuarial value of at least ninety-five percent of the actuarial value of PEBB UMP Classic benefits.

"Presiding officer" means an impartial decision maker who conducts a brief adjudicative proceeding and is a director-designated HCA employee.

"Public employee" has the same meaning as employee.

"Review officer or officers" means one or more delegates from the director that consider appeals relating to the administration of PEBB benefits by the PEBB program.

"Salary reduction plan" means a benefit plan whereby public employees may agree to a reduction of salary on a pretax basis to participate in the dependent care assistance program, medical flexible spending arrangement, or premium payment plan offered pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"Service" or "serve" means the process described in WAC 182-16-058.

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

"State registered domestic partner" has the same meaning as defined in RCW 26.60.020(1) and substantially equivalent legal unions from other jurisdictions as defined in RCW 26.60.090.

"Subscriber" means the employee, retiree, continuation coverage enrollee, or survivor who has been determined eligible by the PEBB program, employer group, or state agency, is enrolled in PEBB benefits, and is the individual to whom the PEBB program and contracted vendors will issue all notices, information, requests, and premium bills on behalf of an enrollee.

"Tobacco products" means any product made with or derived from tobacco that is intended for human consumption, including any component, part, or accessory of a tobacco product. This includes, but is not limited to, cigars, cigarettes, pipe tobacco, chewing tobacco, snuff, and other tobacco products. It does not include e-cigarettes or United States Food and Drug Administration (FDA) approved quit aids.

"Tobacco use" means any use of tobacco products within the past two months. Tobacco use, however, does not include the religious or ceremonial use of tobacco.

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

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-058 Service or serve. (1) When the rules in this chapter or in other public employees benefits board (PEBB) program rules or statutes require a party to serve copies of documents on other parties, a party must send copies of the documents to all other parties or their representatives as described in this chapter. In this section, requirements for service or delivery by a party apply also when service is required by the presiding officer, review officer or officers, or hearing officer.

(2) Unless otherwise stated in applicable law, documents may be sent only as identified in this chapter to accomplish service. A party may serve someone by:

(a) Personal service (hand delivery);

(b) First class, registered, or certified mail sent via the United States Postal Service or Washington state consolidated mail services;

(c) Fax;

(d) Commercial delivery service; or

(e) Legal messenger service.

(3) A party must serve all other parties or their representatives whenever the party files a motion, pleading, brief, or other document with the presiding officer, review officer or officers, or hearing officer's office, or when required by law.

(4) Service is complete when:

(a) Personal service is made;

(b) Mail is properly stamped, addressed, and deposited in the United States Postal Service;

(c) Mail is properly addressed, and deposited in the Washington state consolidated mail services;

(d) Fax produces proof of transmission;

(e) A parcel is delivered to a commercial delivery service with charges prepaid; or

(f) A parcel is delivered to a legal messenger service with charges prepaid.

(5) A party may prove service by providing any of the following:

(a) A signed affidavit of mailing or certificate of ((~~mailing~~)) service;

(b) The certified mail receipt signed by the person who received the parcel;

(c) A signed receipt from the person who accepted the commercial delivery service or legal messenger service parcel;

(d) Proof of fax transmission.

(6) Service cannot be made by electronic mail unless mutually agreed to in advance and in writing by the parties.

(7) If the document is a subpoena, follow the compliance procedure as described in WAC 182-16-3130.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-066 Burden of proof, standard of proof, and presumptions. (1) The burden of proof is a party's responsibility to provide evidence regarding disputed facts and persuade the presiding officer, review officer or officers, or hearing officer that a position is correct based on the standard of proof. Unless stated otherwise in rules or law, the appellant has the burden of proof in a brief adjudicative proceeding or formal administrative hearing.

(2) Standard of proof refers to the amount of evidence needed to prove a party's position. Unless stated otherwise in rules or law, the standard of proof in a brief adjudicative proceeding or formal administrative hearing is a preponderance of the evidence, meaning that something is more likely to be true than not.

(3) Public officers and state agencies are presumed to have properly performed their duties and acted as described in the law, unless substantial evidence to the contrary is presented. A party challenging this presumption bears the burden of proof.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-120 Computation of time. (1) In computing any period of time prescribed by this chapter, the day of the event from which the time begins to run is not included. (For example, if an initial order is served on Friday and the party has twenty-one days to request a review, start counting the days with Saturday.)

(2) As provided in subsection (3) of this section, the last day of the period so computed is included unless it is a Saturday, Sunday, or legal holiday as defined in RCW 1.16.050, in which case the period extends to ((~~the end of~~)) the next business day.

(3) When the period of time prescribed or allowed is ten days or less, intermediate Saturdays, Sundays and state legal holidays ((~~shall~~)) must be excluded in the computation.

(4) The deadline is 5:00 p.m. on the last day of the computed period.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-130 Index of significant decisions. (1) A final ((~~decision~~)) order may be relied upon, used, or cited as precedent by a party only if the final order has been indexed in the authority's index of significant decisions in accordance with RCW 34.05.473 (1)(b).

(2) An index of significant decisions is available to the public on the health care authority's (HCA) website. As decisions are indexed they will be available on the website.

(3) A final ((~~decision~~)) order published in the index of significant decisions may be removed from the index when:

(a) A published decision entered by the court of appeals or the supreme court reverses an indexed final ((~~decision~~)) order; or

(b) HCA determines that the indexed final ((~~decision~~)) order is no longer precedential due to changes in statute, rule, or policy.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-2010 Appealing a decision regarding public employees benefits board (PEBB) eligibility, enrollment, premium payments, premium surcharges, a wellness incentive, or the administration of benefits. (1) Any current or former employee of a state agency or their dependent aggrieved by a decision made by the state agency with regard to public employees benefits board (PEBB) eligibility, enrollment, or premium surcharges may appeal that decision to the state agency by the process described in WAC 182-16-2020.

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

(2) Any current or former employee of an employer group or their dependent who is aggrieved by a decision made by an employer group with regard to PEBB eligibility, enrollment, or premium surcharges may appeal that decision to the employer group through the process established by the employer group.

Exception: Any current or former employee of an employer group aggrieved by a decision regarding life insurance, long-term disability (LTD) insurance, eligibility to participate in the PEBB wellness incentive program, or eligibility to receive a PEBB wellness incentive may appeal that decision to the PEBB appeals unit by the process described in WAC 182-16-2030.

(3) Any subscriber or dependent aggrieved by a decision made by the PEBB program with regard to PEBB eligibility, enrollment, premium payments, premium surcharges, eligibility to participate in the PEBB wellness incentive program, or eligibility to receive a PEBB wellness incentive, may appeal that decision to the PEBB appeals unit by the process described in WAC 182-16-2030.

(4) Any enrollee aggrieved by a decision regarding the administration of ((~~a health plan~~)) PEBB medical and dental, life insurance, accidental death and dismemberment (AD&D) insurance, or long-term disability insurance may appeal that decision by following the appeal provisions of those plans, with the exception of:

(a) Enrollment decisions;

(b) Premium payment decisions other than life insurance or AD&D insurance premium payment decisions; and

(c) Eligibility decisions.

(5) Any PEBB enrollee aggrieved by a decision regarding the administration of PEBB long-term care insurance or property and casualty insurance may appeal that decision by following the appeal provisions of those plans.

(6) Any PEBB employee aggrieved by a decision regarding the administration of a benefit offered under the ((~~state's~~)) salary reduction plan may appeal that decision by the process described in WAC 182-16-2050.

(7) Any subscriber aggrieved by a decision made by the PEBB wellness incentive program contracted vendor regarding the completion of the PEBB wellness incentive program requirements, or a request for a reasonable alternative to a wellness incentive program requirement, may appeal that decision by the process described in WAC 182-16-2040.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-2020 Appealing a decision made by a state agency about eligibility, premium surcharges, or enrollment in benefits. (1) An eligibility, premium surcharges, or enrollment decision made by a state agency may be appealed by submitting a written request for administrative review to the state agency. The state agency must receive

the request for administrative review no later than thirty days after the date of the denial notice. The contents of the request for administrative review are to be provided as described in WAC 182-16-2070.

(a) Upon receiving the request for administrative review, the state agency must perform a complete review of the denial by one or more staff who did not take part in the decision resulting in the denial.

(b) The state agency must render a written decision within thirty days of receiving the written request for administrative review. The written decision must be sent to the employee or employee's dependent who submitted the request for administrative review and must include a description of the appeal rights. The state agency must also send a copy of the state agency's written decision to the state agency's administrator (or designee) and to the public employees benefits board (PEBB) appeals unit. If a state agency fails to render a written decision within thirty days of receiving the written request for administrative review, the request for administrative review may be considered denied as of the thirty-first day and the original underlying state agency decision may be appealed to the PEBB appeals unit by following the process in this section.

(c) The state agency may reverse eligibility, premium surcharges, or enrollment decisions as permitted by WAC 182-08-187.

(2) Any current or former employee or employee's dependent who disagrees with the state agency's decision in response to a written request for administrative review, as described in subsection (1) of this section, may request a brief adjudicative proceeding to be conducted by the authority by submitting a written request to the PEBB appeals unit.

(a) The PEBB appeals unit must receive the request for a brief adjudicative proceeding no later than thirty days after the date of the state agency's written decision on the request for administrative review. If a state agency fails to render a written decision within thirty days of receiving a written request for administrative review, the PEBB appeals unit must receive the request for a brief adjudicative proceeding no later than thirty days after the date the request for administrative review was deemed denied. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(i) The PEBB appeals unit must notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(ii) Once the PEBB appeals unit receives a request for a brief adjudicative proceeding, the PEBB appeals unit will send a request for documentation and information to the applicable state agency. The state agency will then have two business days to respond to the request and provide the requested documentation and information. The state agency will also send a copy of the documentation and information to the appellant.

(iii) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(b) If an employee fails to timely request a brief adjudicative proceeding ((~~to appeal the state agency's written decision within thirty days by following the process in (a) of this subsection~~)), the state agency's prior written decision becomes the ((~~health care~~)) authority's final ((~~decision~~)) order without further action.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-2030 Appealing a public employees benefits board (PEBB) program decision regarding eligibility, enrollment, premium payments, premium surcharges, a PEBB wellness incentive, or certain decisions made by an employer group. (1) A decision made by the public employees benefits board (PEBB) program regarding eligibility, enrollment, premium payments, premium surcharges, or a PEBB wellness incentive, may be appealed by submitting a request to the PEBB appeals unit for a brief adjudicative proceeding to be conducted by the authority.

(2) A decision made by an employer group regarding life insurance, LTD insurance, eligibility to participate in the PEBB wellness incentive program, or eligibility to receive a PEBB wellness incentive, may be appealed by submitting a request to the PEBB appeals unit for a brief adjudicative proceeding to be conducted by the authority.

(3) The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(4) The request for a brief adjudicative proceeding from a current or former employee or employee's dependent must be received by the PEBB appeals unit no later than thirty days after the date of the denial notice.

(5) The request for a brief adjudicative proceeding from a retiree, self-pay enrollee, or dependent of a retiree or self-pay enrollee must be received by the PEBB appeals unit no later than sixty days after the date of the denial notice.

(6) The PEBB appeals unit must notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(7) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(8) Failing to timely request a brief adjudicative proceeding ((~~to appeal a decision made under this section within the applicable time frame described in subsections (4) and (5) of this section,~~)) will result in the prior PEBB program decision becoming the authority's final ((~~decision~~)) order without further action.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-2040 How can a subscriber appeal a decision regarding the administration of wellness incentive program requirements? (1) Any subscriber aggrieved by a decision regarding the completion of the wellness incentive program requirements, or request for a reasonable alternative to a wellness incentive program requirement, may appeal that decision to the public employees benefits board (PEBB) wellness incentive program contracted vendor.

(2) Any subscriber who disagrees with a decision in response to an appeal filed with the PEBB wellness incentive program contracted vendor may appeal the decision by submitting a request for a brief adjudicative proceeding to the PEBB appeals unit.

(a) The request for a brief adjudicative proceeding from a current or former employee must be received by the PEBB appeals unit no later than thirty days after the date of the denial notice. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(b) The request for a brief adjudicative proceeding from a retiree or self-pay subscriber must be received by the PEBB appeals unit no later than sixty days after the date of the denial notice. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(3) The PEBB appeals unit must notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(4) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(5) If a subscriber fails to timely request a brief adjudicative proceeding ((~~of a decision made under subsection (1) of this section within thirty days by following the process in WAC 182-16-2020(2)~~)), the decision of the PEBB wellness incentive program contracted vendor becomes the authority's final ((~~decision~~)) order without further action.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-2050 How can an employee appeal a decision regarding the administration of benefits offered under the salary reduction plan? (1) Any employee who disagrees with a decision that denies eligibility for, or enrollment in, a benefit offered under the salary reduction plan may appeal that decision by submitting a written request for administrative review to their state agency. The state agency must receive the written request for administrative review no later than thirty days after the date of the denial. The contents of the written request for administrative review are to be provided as described in WAC 182-16-2070.

(a) Upon receiving the written request for administrative review, the state agency must perform a complete review of the denial by one or more staff who did not take part in the decision resulting in the denial.

(b) The state agency must render a written decision within thirty days of receiving the written request for administrative review. The written decision must be sent to the employee who submitted the written request for review and must include a description of appeal rights. The state agency must also send a copy of the state agency's written decision to the state agency's administrator (or designee) and to the PEBB appeals unit. If a state agency fails to render a written decision within thirty days of receiving the written request for administrative review, the request for administrative review may be considered denied as of the thirty-first day and the original underlying state agency decision may be appealed to the PEBB appeals unit by following the process in this section.

(2) Any employee who disagrees with the state agency's decision in response to a written request for administrative review, as described in this section, may request a brief adjudicative proceeding to be conducted by the authority by submitting a written request to the PEBB appeals unit.

(a) The PEBB appeals unit must receive the request for a brief adjudicative proceeding no later than thirty days after the date of the state agency's written decision on the request for administrative review. If a state agency fails to render a written decision within thirty days of receiving a written request for administrative review, the PEBB appeals unit must receive the request for a brief adjudicative proceeding no later than thirty days after the date the request for administrative review was deemed denied. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(i) The PEBB appeals unit must notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(ii) Once the PEBB appeals unit receives a request for a brief adjudicative proceeding, the PEBB appeals unit will send a request for documentation and information to the applicable state agency. The state agency will then have two business days to respond to the request and provide the documentation and information requested. The state agency will also send a copy of the documentation and information to the employee.

(iii) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(b) If an employee fails to timely request a brief adjudicative proceeding ((~~to appeal a decision made under this section within thirty days by following the process described in this subsection~~)), the state agency's prior written decision becomes the authority's final ((~~decision~~)) order without further action.

(3) Any employee aggrieved by a decision regarding a claim for benefits under the medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP) offered under the salary reduction plan may appeal that decision to the authority's contracted vendor by following the appeal process of that contracted vendor.

(a) Any employee who disagrees with a decision in response to an appeal filed with the contracted vendor that administers the medical FSA and DCAP under the salary reduction plan may request a brief adjudicative proceeding by submitting a written request to the PEBB appeals unit. The PEBB appeals unit must receive the request for a brief adjudicative proceeding no later than thirty days after the date of the contracted vendor's appeal decision. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(i) The PEBB appeals unit must notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(ii) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(b) If an employee fails to timely request a brief adjudicative proceeding ((~~to appeal a decision made under this section within thirty days by following the process described in this subsection~~)), the contracted vendor's prior written decision becomes the authority's final ((~~decision~~)) order without further action.

(4) Any employee aggrieved by a decision regarding the administration of the premium payment plan offered under the salary reduction plan may request a brief adjudicative proceeding to be conducted by the authority by submitting a written request to the PEBB appeals unit for a brief adjudicative proceeding.

(a) The PEBB appeals unit must receive the request for a brief adjudicative proceeding no later than thirty days after the date of the denial notice by the PEBB program. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(i) The PEBB appeals unit must notify the appellant in writing when the notice of appeal has been received.

(ii) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(b) If an employee fails to timely request a brief adjudicative proceeding ((~~to appeal a decision made under this section within thirty days by following the process described in this subsection~~)), the PEBB program's prior written decision becomes the authority's final ((~~decision~~)) order without further action.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-2060 How can an entity or organization appeal a decision of the health care authority to deny an employer group application? (1) An entity or organization whose employer group application is denied by the authority may appeal the decision by submitting a request for a brief adjudicative proceeding to the public employees benefits board (PEBB) appeals unit. For rules regarding eligible entities, see WAC 182-12-111.

(2) The PEBB appeals unit must receive the request for a brief adjudicative proceeding no later than thirty days after the date of the denial notice. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(3) The PEBB appeals unit must notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(4) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(5) Failing to timely request a brief adjudicative proceeding ((~~to appeal a decision made under this section within thirty days by following the process described in subsection (2) of this section,~~)) will result in the prior PEBB program decision becoming the authority's final ((~~decision~~)) order without further action.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2070 What should a written request for administrative review and a request for brief adjudicative proceeding contain? A written request for administrative review of the employing agency decision and a request for brief adjudicative proceeding should contain:

(1) The name and mailing address of the party requesting an administrative review or the brief adjudicative proceeding;

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

(3) Documentation, or reference to documentation, of decisions previously rendered through the appeal process, if any;

(4) A statement identifying the specific portion of the decision being appealed and clarifying what is believed to be unlawful or in error;

(5) A statement of facts in support of the appealing party's position;

(6) Any information or documentation that the appealing party would like considered;

(7) The type of relief sought; and

(8) The signature of the appealing party or the appealing party's representative.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-2085 Continuances. The presiding officer or review officer or officers may grant, in their sole discretion, a request for a continuance on motion of the appellant, the authority, or on their own ((~~motion~~)). The continuance may be up to thirty calendar days.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-2090 Initial order. Unless a continuance has been granted, within ten days after the public employees benefits board (PEBB) appeals unit receives a request for a brief adjudicative proceeding, the presiding officer ((~~shall~~)) must render a written initial order that addresses the issue or issues raised by the appellant in their appeal. The presiding officer must serve a copy of the initial order on all parties and the initial order must contain information on how the appellant may request review of the initial order.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-2100 How to request a review of an initial order resulting from a brief adjudicative proceeding. (1) An appellant who has received an initial order upholding an employing agency decision, public employees benefits board (PEBB) program decision, or a decision made by a PEBB program contracted vendor, may request review of the initial order by the authority. The appellant must file a written request for review of the initial order or make an oral request for review of the initial order with the PEBB appeals unit within twenty-one days after service of the initial order. The written or oral request for review of the initial order must be made by using the contact information included in the initial order. If the appellant fails to request review of the initial order within twenty-one days, the initial order becomes the authority's final order without further action ((~~by the authority~~)).

(2) Upon timely request by the appellant, a review of an initial order will be performed by one or more review officers designated by the director of the authority.

(3) If the appellant has not requested review, the authority may review an order resulting from a brief adjudicative proceeding on its own ((~~motion~~)), and without notice to the parties, but it may not take action on review less favorable to any party than the initial order without giving that party notice and an opportunity to explain that party's view of the matter.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2110 Final order. (1) A final order issued by the review officer or officers will be ((~~issued~~)) in writing and include a brief statement of the reasons for the decision.

(2) The final order must be ((~~rendered and~~)) served within twenty days of the date of the initial order or of the date the request for review of the initial order was received by the PEBB appeals unit, whichever is later.

(3) The final order will include a notice that reconsideration and judicial review may be available.

(4) A request for review of the initial order is deemed denied if the authority does not issue a final order within twenty days after the request for review of the initial order is filed.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-2120 Request for reconsideration. (1) A request for reconsideration asks the review officer or officers to reconsider the final order because the party believes the review officer or officers made a mistake of law, mistake of fact, or clerical error.

(2) A request for reconsideration must state in writing why the party wants the final order to be reconsidered.

(3) Requests for reconsideration must be filed with the review officer or officers who entered the final order.

(4) If a party files a request for reconsideration:

(a) The review officer or officers must receive the request for reconsideration on or before the tenth business day after the service date of the final order((~~.~~));

(b) The party filing the request must send copies of the request to all other parties((~~.~~)); and

(c) Within five business days of receiving a request for reconsideration, the review officer or officers must serve all parties a notice that provides the date the request for reconsideration was received.

(5) The other parties may respond to the request for reconsideration. The response must state in writing why the final order should stand. Responses are optional. If a party chooses not to respond, that party will not be prejudiced because of that choice.

(a) Responses to a request for reconsideration must be received by the review officer or officers no later than seven business days after the service date of the review ((~~officer's~~)) officer or officers' notice as described in subsection (4)(c) of this section, or the response will not be considered.

(b) Service of responses to a request for reconsideration must be made to all parties.

(6) If a party needs more time to file a request for reconsideration or respond to a request for reconsideration, the review officer or officers may extend the required time frame if the party makes a written request providing a good reason for the request within the required time frame.

(7) Unless the request for reconsideration is denied as untimely filed under ((~~WAC 182-16-2120~~)) subsection (4)(a) of this section, the same review officer or officers who entered the final order, if reasonably available, will also consider the request as well as any responses received.

(8) The decision on the request for reconsideration must be in the form of a written order denying the request, granting the request in whole or in part and issuing a new written final order, or granting the ((~~petition~~)) request and setting the matter for further hearing.

(9) If the review officer or officers do not send an order on the request for reconsideration within twenty calendar days of the date of the notice described in subsection (4)(c) of this section, the request is deemed denied.

(10) If any party files a request for reconsideration of the final order, the reconsideration process must be completed before any judicial review may be requested. However, the filing of a ((~~petition~~)) request for reconsideration is not required before requesting judicial review.

(11) An order denying a request for reconsideration is not subject to judicial review.

(12) No evidence may be offered in support of a motion for reconsideration, except newly discovered evidence that is material for the party moving for reconsideration and that the party could not with reasonable diligence have discovered and produced prior to the final order being issued.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-2150 Review officer or officers—Designation and authority. (1) The designation of a review officer or officers ((~~shall~~)) must be consistent with the requirements of RCW 34.05.491 and the review officer or officers ((~~shall~~)) must not have personally participated in the decision made by the employing agency or PEBB program.

(2) The review officer or officers ((~~shall~~)) must review the initial order and the record to determine if the initial order was correctly decided.

(3) The review officer or officers will issue a final order that will either:

(a) Affirm the initial order in whole or in part; or

(b) Reverse the initial order in whole or in part; or

(c) ((~~Refer~~)) Convert the matter ((~~for~~)) to a formal administrative hearing; or

(d) Remand to the presiding officer in whole or in part.

(4) A review officer or officers are limited to those powers granted by the state constitution, statutes, rules, or applicable case law.

(5) A review officer or officers may not decide that a rule is invalid or unenforceable.

(6) In addition to the record, the review officer or officers may employ the authority's expertise as a basis for the decision.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-2160 Conversion of a brief adjudicative proceeding to a formal administrative hearing. (1) The presiding officer or the review officer or officers, in their sole discretion, may convert a brief adjudicative proceeding to a formal administrative hearing at any time on motion by the subscriber or enrollee or their representative, the authority, or on the presiding officer or review officer or officers' own ((~~motion~~)).

(2) The presiding officer or review officer or officers must convert the brief adjudicative proceeding to a formal administrative hearing when it is found that the use of the brief adjudicative proceeding violates any provision of law, when the protection of the public interest requires the authority to give notice and an opportunity to participate to persons other than the parties, or when the issues and interests involved in the controversy warrant the use of the procedures or RCW 34.05.413 through 34.05.476 that govern formal administrative hearings.

(3) When a brief adjudicative proceeding is converted to a formal administrative hearing, the director designates a hearing officer to conduct the formal administrative hearing upon notice to the subscriber or enrollee and the authority.

(4) When a brief adjudicative proceeding is converted to a formal administrative hearing, WAC 182-16-010 through 182-16-130 and 182-16-3000 through 182-16-3200 apply to the formal administrative hearing.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-3000 Formal administrative hearings. (1) When a brief adjudicative proceeding is converted to a formal administrative hearing consistent with WAC 182-16-2160, the director designates a hearing officer to conduct the formal administrative hearing.

(2) Formal administrative hearings are conducted consistent with the Administrative Procedure Act, RCW 34.05.413 through 34.05.476.

(3) Part III describes the general rules and procedures that apply to public employees benefits board (PEBB) benefits formal administrative hearings.

(a) Part III supplements the Administrative Procedure Act (APA), chapter 34.05 RCW, and the model rules of procedure in chapter 10-08 WAC. The model rules of procedure adopted by the chief administrative law judge pursuant to RCW 34.05.250, as now or hereafter amended, are hereby adopted for use by the authority in public employees benefits board (PEBB) benefits formal administrative hearings. Other procedural rules adopted in chapters 182-08, 182-12, and 182-16 WAC are supplementary to the model rules of procedure.

(b) In the case of a conflict between the model rules of procedure and ((~~this~~)) Part III, the procedural rules adopted in ((~~this~~)) Part III must govern.

(c) If there is a conflict between ((~~this~~)) Part III and specific PEBB program rules, the specific PEBB program rules prevail. PEBB program rules are found in chapters 182-08 and 182-12 WAC.

(d) Nothing in ((~~this~~)) Part III is intended to affect the constitutional rights of any person or to limit or change additional requirements imposed by statute or other rule. Other laws or rules determine if a hearing right exists, including the APA and program rules or laws.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-3030 Authority of the hearing officer. (1) A hearing officer must hear and decide the issues based on the evidence and oral or written arguments presented during a formal administrative hearing and admitted into the record.

(2) A hearing officer has no inherent or common law powers, and is limited to those powers granted by the state constitution, statutes, or rules.

(3) A hearing officer may not decide that a rule is invalid or unenforceable. If the validity of a rule is raised during a formal administrative hearing, the hearing officer may allow ((~~only~~)) argument only to preserve the record for judicial review.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-3100 Rescheduling and continuances for formal administrative hearings. (1) Any party may request the hearing officer to reschedule a formal administrative hearing if a rule requires notice of a hearing and the amount of notice required was not provided.

(a) The hearing officer must reschedule the formal administrative hearing under circumstances identified in this chapter if requested by any party.

(b) The parties may agree to shorten the amount of notice required by any rule.

(2) Any party may request a continuance of a formal administrative hearing either orally or in writing.

(a) In each formal administrative hearing, the hearing officer must grant each party's first request for a continuance. The continuance may be up to thirty calendar days.

(b) The hearing officer may grant each party up to one additional continuance of up to thirty calendar days because of extraordinary circumstances.

(c) After granting a continuance, the hearing officer or their designee must((~~:~~

~~(i) Immediately telephone all other parties to inform them the hearing was continued; and~~

~~(ii)~~)) serve an order of continuance on the parties no later than fourteen days before the new formal administrative hearing date. All orders of continuance must provide a new deadline for filing documents with the hearing officer. The new filing deadline can be no less than ten calendar days prior to the new formal administrative hearing date. If the continuance is granted pursuant to (b) of this subsection, then the order of continuance must also include findings of fact that state with specificity the extraordinary circumstances for which the hearing officer granted the continuance.

(3) Regardless of whether a party has been granted a continuance as described in subsection (2)(b) of this section, the hearing officer must grant a continuance if a new material

issue is raised during the formal administrative hearing and a party requests a continuance.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-3120 Dispositive motions. (1) A dispositive motion could dispose of one or all the issues in a formal administrative hearing, such as a motion to dismiss or motion for summary judgment.

(2) To request a dispositive motion hearing a party must file a written dispositive motion with the hearing officer and serve a copy of the motion to all other parties. The hearing officer may also set a dispositive motion hearing, and request briefing from the parties, to address any possible dispositive issues the hearing officer believes must be addressed before the hearing.

(3) The deadline to file a timely dispositive motion must be ten calendar days before the scheduled hearing.

(4) Upon receiving a dispositive motion, a hearing officer:

(a) Must convert the scheduled hearing to a dispositive motion hearing when:

(i) The dispositive motion is timely filed with the hearing officer at least ten calendar days before the date of the hearing; and

(ii) The party filing the dispositive motion has not previously filed a dispositive motion.

(b) May schedule a dispositive motion hearing in all instances other than described in (a) of this subsection.

(5) The hearing officer may conduct the dispositive motion hearing in person or by telephone conference. For dispositive motion hearings scheduled to be held in person, the HCA hearing representative may choose to attend and participate in person or by telephone conference call.

(6) The party requesting the dispositive motion hearing must attend and participate in the dispositive motion hearing in person or by telephone. If the party requesting the motion hearing does not attend and participate in the dispositive motion hearing, the hearing officer will enter an order dismissing the dispositive motion.

(7) During a dispositive motion hearing, the hearing officer can only consider the filed dispositive motions, any response to the motions, evidence submitted to support or oppose the motions, and argument on the motions. Prior to rescheduling any necessary hearings, the hearing officer must serve a written order on the dispositive motions.

(8) The hearing officer must serve the written order on the dispositive motions to all parties no later than eighteen calendar days after the dispositive motion hearing is held. Orders on dispositive motions are subject to motions for reconsideration or petitions for judicial review as described in WAC ((~~182-16-2120 and 182-16-2130~~)) 182-16-3180 and 182-16-3200.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-3130 Subpoenas. (1) Hearing officers, the health care authority (HCA) hearing representative, and attorneys for the parties may prepare subpoenas as described in Washington state civil rule 45, unless otherwise prohibited by law. Any party may request the hearing officer prepare a subpoena on their behalf.

(2) The hearing officer may schedule a prehearing conference to decide whether to issue a subpoena.

(3) If a party requests the hearing officer prepare a subpoena on its behalf, the party is responsible for:

(a) Service of the subpoena; and

(b) Any costs associated with:

(i) Compliance with the subpoena; and

(ii) Witness fees as described in RCW 34.05.446(7).

(4) Service of a subpoena must be made by a person who is at least eighteen years old and not a party to the hearing. Service of the subpoena is complete when the person serving the subpoena:

(a) Gives the person or entity named in the subpoena a copy of the subpoena; or

(b) Leaves a copy of the subpoena with a person over the age of eighteen at the residence or place of business of the person or entity named in the subpoena.

(5) To prove service of a subpoena on a witness, the person serving the subpoena must file with the hearing officer's office a signed, written, and dated statement that includes:

(a) The name of the person to whom service of the subpoena occurred;

(b) The date the service of the subpoena occurred;

(c) The address where the service of the subpoena occurred; and

(d) The name, age, and address of the person who provided service of the subpoena.

(6) A person or entity subject to or affected by the subpoena may request the hearing officer quash (set aside) or change a subpoena request at any time before the deadline given in the subpoena.

(7) A hearing officer may quash (set aside) or change a subpoena if it is unreasonable.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-3140 Orders of dismissal—Reinstating a formal administrative hearing after an order of dismissal. (1) An order of dismissal is an order from the hearing officer ending the matter. The order is entered because the party who made the appeal withdrew from the proceeding, the appellant is no longer aggrieved, the hearing officer granted a dispositive motion dismissing the matter, or the hearing officer entered an order of default because the party who made the appeal failed to attend or refused to participate in a prehearing conference or the formal administrative hearing.

(2) The order of dismissal becomes a final order if no party files a request to vacate the order as described in subsections (3) through (7) of this section.

(3) If the hearing officer enters and serves an order dismissing the formal administrative hearing, the appellant may file a written request to vacate (set aside) the order of dismissal. Upon receipt of a request to vacate an order of dismissal, the hearing officer must schedule and serve notice of a prehearing conference as described in WAC 182-16-3080.

At the prehearing conference, the party asking that the order of dismissal be vacated has the burden to show good cause according to subsection (8) of this section for an order of dismissal to be vacated and the matter to be reinstated.

(4) The request to vacate an order of dismissal must be filed with the hearing officer and the other parties. The party requesting that an order of dismissal be vacated should specify in the request with good cause why the order of dismissal should be vacated.

(5) The request to vacate an order of dismissal must be filed with the hearing officer no later than twenty-one calendar days after the date the order of dismissal was entered. If no request is received within that deadline, the dismissal order becomes the health care authority's final decision without further action.

(6) If the hearing officer finds good cause, as described in subsection (8) of this section, for the order of dismissal to be vacated, the hearing officer must enter and serve a written order to the parties setting forth the findings of fact, conclusions of law, and the reinstatement of the matter.

(7) If the order of dismissal is vacated, the hearing officer will conduct a formal administrative hearing at which the parties may present argument and evidence about issues raised in the original appeal. The formal administrative hearing may occur immediately following the prehearing conference on the request to vacate only if agreed to by the parties and the hearing officer, otherwise a formal administrative hearing date must be scheduled by the hearing officer.

(8) Good cause is a substantial reason or legal justification for failing to appear, act, or respond to an action using the provisions of Superior Court civil rule 60 as a guideline. ((~~This good cause exception applies only to this chapter.~~)) This good cause exception does not apply to any other chapter ((~~or chapters~~)) in Title 182 WAC except WAC 182-32-3140(8).

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-3170 Final order deadline—Required information. (1) Within ninety days after the formal administrative hearing record is closed, the hearing officer must serve ((~~a final order that must be the final decision of the authority. The hearing officer shall serve~~)) a copy of the final order to all parties.

(2) ((~~The hearing officer must include the following information~~)) In the written final order, the hearing officer must:

(a) Identify the order as a final order of the public employees benefits board (PEBB) program;

(b) List the name and docket number of the case and the names of all parties and representatives;

(c) Enter findings of fact used to resolve the dispute based on the evidence admitted in the record;

(d) Explain why evidence is, or is not, credible when describing the weight given to evidence related to disputed facts;

(e) State the law that applies to the dispute;

(f) Apply the law to the facts of the case in the conclusions of law;

(g) Discuss the reasons for the decision based on the facts and the law;

(h) State the result and remedy ordered; and

(i) Include any other information required by law or program rules.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-3180 Request for reconsideration and response—Process. (1) A request for reconsideration asks the hearing officer to reconsider the final order because the party believes the hearing officer made a mistake of law, mistake of fact, or clerical error.

(2) A request for reconsideration must state in writing why the party wants the final order to be reconsidered.

(3) Requests for reconsideration must be filed with the hearing officer who entered the final order.

(4) If a party files a request for reconsideration:

(a) The hearing officer must receive the request for reconsideration on or before the tenth business day after the service date of the final order;

(b) The party filing the request must serve copies of the request on all other parties on the same day the request is served on the hearing officer; and

(c) Within five business days of receiving a request for reconsideration, the hearing officer must serve to all parties a notice that provides the date the request for reconsideration was received.

(5) The other parties may respond to the request for reconsideration. The response must state in writing why the final order should stand. Responses are optional. If a party chooses not to respond, that party will not be prejudiced because of that choice.

(a) Responses to a request for reconsideration must be received by the hearing officer no later than seven business days after the service date of the hearing officer's notice as described in subsection (4)(c) of this section, or the response will not be considered.

(b) Service of responses to a request for reconsideration must be made to all parties.

(6) If a party needs more time to file a request for reconsideration or respond to a request for reconsideration, the hearing officer may extend the required time frame if the party makes a written request providing a good reason for the request within the required time frame.

(7) No evidence may be offered in support of a motion for ((~~re-consideration~~)) reconsideration, except newly discovered evidence that is material for the party moving for reconsideration and that the party could not with reasonable diligence have ((~~reasonably~~)) discovered and produced ((~~at the hearing or before the ruling on a dispositive motion~~)) prior to the final order being issued.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-3190 Decisions on requests for reconsideration. (1) Unless the request for reconsideration is denied as untimely filed under WAC 182-16-3180, the same hearing officer who entered the final order, if reasonably

available, will also ((~~dispose of~~)) decide the request as well as any responses received.

(2) The decision on the request for reconsideration must be in the form of a written order denying or granting the request in whole or in part and if the request is granted issuing a new written final order.

(3) If the hearing officer does not send an order on the request for reconsideration within twenty calendar days of the date of the notice described in WAC 182-16-3180 (4)(c), the request is deemed denied.

(4) If any party files a request for reconsideration of the final order, the reconsideration process must be completed before any judicial review may be requested. However, the filing of a request for reconsideration is not required before requesting judicial review.

(5) An order denying a request for reconsideration is not subject to judicial review.

WSR 20-13-074
PROPOSED RULES
HEALTH CARE AUTHORITY
(Public Employees Benefits Board)

[Admin # 2020-01—Filed June 16, 2020, 8:11 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 20-09-117.

Title of Rule and Other Identifying Information: **The following section in chapter 182-08 WAC is revised:** WAC 182-08-197 When must a newly eligible employee, or an employee who regains eligibility for the employer contribution, elect public employees benefits board (PEBB) benefits and complete required forms?

Hearing Location(s): On July 21, 2020, at 10:00 a.m.

As more counties move into Phase 2 of the Governor's Safe Start plan, it is yet unknown whether by the date of this public hearing restrictions of meeting in public places will be eased. Therefore, this hearing is being held virtually only. This will not be an in-person hearing and there is not a physical location available.

Please register for HCA Public WAC Hearing - 7/21/2020 on July 21, 2020, 10:00 a.m. PDT at https://attendee.gotowebinar.com/register/6074456904428252685.

After registering, you will receive a confirmation email containing information about joining the webinar.

Date of Intended Adoption: Not sooner than July 22, 2020.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, by July 21, 2020.

Assistance for Persons with Disabilities: Contact Amber Lougheed, phone 360-725-1349, fax 360-586-9727, telecommunications relay services 711, email amber.lougheed@hca.wa.gov, by July 10, 2020.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The purpose of this proposal is to amend WAC 182-08-197 to support the PEBB program.

1. Implement PEBB Policy Resolution 2020-04 by amending default elections for an eligible employee who fails to timely elect coverage.

2. Make technical amendments to WAC 182-08-197:

- To add a contracted vendor must receive required forms no later than thirty-one days after the employee becomes eligible for PEBB benefits;
- To include an employee may enroll in supplemental death and dismemberment insurance with the contracted vendor at any time without evidence of insurability;
- To clarify enrollment if a newly eligible employee's employing agency or the HCA's contracted vendor does not receive elections within thirty-one days;
- To clarify rules related to an employee regains [regaining] eligibility for the employer contribution toward PEBB benefits; and
- To clarify PEBB benefits and supplemental coverage throughout the WAC section.

Reasons Supporting Proposal: See purpose statement.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160, PEBB Policy Resolution 2020-04.

Statute Being Implemented: RCW 41.05.021, 41.05.160.

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

Name of Proponent: Health care authority (HCA), governmental.

Name of Agency Personnel Responsible for Drafting: Rob Parkman, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-0883; Implementation: Barbara Scott, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-0830; and Enforcement: Scott Palafox, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-1858.

A school district fiscal impact statement is not required under RCW 28A.305.135.

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

The proposed rule does not impose more-than-minor costs on businesses. Following is a summary of the agency's analysis showing how costs were calculated. These rules do not apply to small businesses.

June 16, 2020
Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-08-197 When must a newly eligible employee, or an employee who regains eligibility for the employer contribution, elect public employees benefits board (PEBB) benefits and complete required forms? An employee who is newly eligible or who regains eligibility for the employer contribution toward public employees benefits board (PEBB) benefits enrolls as described in this section.

(1) When an employee is newly eligible for PEBB benefits:

(a) An employee must complete the required forms indicating their enrollment elections, including an election to waive PEBB medical provided the employee is eligible to waive PEBB medical and elects to waive as described in WAC 182-12-128. The required forms must be returned to the employee's employing agency or contracted vendor. Their employing agency or contracted vendor must receive the forms no later than thirty-one days after the employee becomes eligible for PEBB benefits under WAC 182-12-114.

(i) An employee may enroll in supplemental life((~~, supplemental accidental death and dismemberment (AD&D),~~)) and supplemental long-term disability (LTD) insurance up to the guaranteed issue coverage amount without evidence of insurability if the required forms are returned to the employee's employing agency or contracted vendor as required. An employee may apply for enrollment in supplemental life((~~, supplemental AD&D,~~)) and supplemental LTD insurance over the guaranteed issue coverage amount at any time during the calendar year by submitting the required form to the contracted vendor for approval. An employee may enroll in supplemental accidental death and dismemberment (AD&D) insurance at anytime during the calendar year without evidence of insurability by submitting the required form to the contracted vendor.

(ii) If an employee is eligible to participate in the salary reduction plan (see WAC 182-12-116), the employee will automatically enroll in the premium payment plan upon enrollment in PEBB medical allowing medical premiums to be taken on a pretax basis. To opt out of the premium payment plan, a new employee must complete the required form and return it to their state agency. The form must be received by their state agency no later than thirty-one days after the employee becomes eligible for PEBB benefits.

(iii) If an employee is eligible to participate in the salary reduction plan (see WAC 182-12-116), the employee may enroll in the state's medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP) or both, except as limited by subsection (4) of this section. To enroll in these ((~~supplemental~~)) PEBB benefits, the employee must return the required form to their state agency. The form must be received by the state agency no later than thirty-one days after the employee becomes eligible for PEBB benefits.

(b) If a newly eligible employee's employing agency, or the authority's contracted vendor in the case of life insurance and AD&D insurance, does not receive the employee's required forms indicating medical, dental, life insurance, AD&D insurance, and LTD insurance elections, and the employee's tobacco use status attestation within thirty-one days of the employee becoming eligible, their enrollment will be as follows for those elections not received within thirty-one days:

(i) ((~~Uniform Medical Plan Classic;~~)) A medical plan determined by the health care authority (HCA);

(ii) ((~~Uniform Dental Plan;~~)) A dental plan determined by the HCA;

(iii) Basic life insurance;

(iv) Basic AD&D insurance;

(v) Basic ((~~long-term disability~~)) LTD insurance;

(vi) Dependents will not be enrolled; and

(vii) A tobacco use premium surcharge will be incurred as described in WAC 182-08-185 (1)(b).

(2) The employer contribution toward PEBB ((~~insurance coverage~~)) benefits ends according to WAC 182-12-131. When an employee's employment ends, participation in the salary reduction plan ends.

(3) When an employee regains eligibility for the employer contribution toward PEBB ((~~insurance coverage~~)) benefits, including following a period of leave ((~~(~~))described in WAC 182-12-133(1) ((~~and~~)), or after being between periods of leave as described in WAC 182-12-142 (1) and (2)((~~)~~)), or 182-12-131 (3)(e), PEBB medical and dental begin on the first day of the month the employee is in pay status eight or more hours.

(a) ((~~The~~)) An employee must complete the required forms indicating their enrollment elections, including an election to waive PEBB medical if the employee chooses to waive PEBB medical as described in WAC 182-12-128. The required forms must be returned to the employee's employing agency except as described in (d) of this subsection. Forms must be received by the employing agency, life insurance contracted vendor, or AD&D contracted vendor, if required, no later than thirty-one days after the employee regains eligibility, except as described in ((~~subsection (3)~~)) (a)(i) and (b) of this ((~~section~~)) subsection:

(i) An employee who self-paid for supplemental life insurance or supplemental AD&D coverage after losing eligibility will ((~~have~~)) maintain that level of coverage ((~~reinstated without evidence of insurability effective the first day of the month in which the employee is in pay status eight or more hours~~)) upon return;

(ii) An employee who was eligible to continue supplemental life or supplemental AD&D but discontinued that ((~~PEBB insurance~~)) supplemental coverage must submit evidence of insurability to the contracted vendor if they choose to reenroll when they regain eligibility for the employer contribution;

(iii) An employee who was eligible to continue supplemental LTD insurance but discontinued that ((~~PEBB insurance~~)) supplemental coverage must submit evidence of insurability for supplemental LTD insurance to the contracted vendor when they regain eligibility for the employer contribution.

(b) An employee in any of the following circumstances does not have to return a form indicating supplemental LTD insurance elections. Their supplemental LTD insurance will be automatically reinstated effective the first day of the month they are in pay status eight or more hours:

(i) The employee continued to self-pay for their supplemental LTD insurance after losing eligibility for the employer contribution;

(ii) The employee was not eligible to continue supplemental LTD insurance after losing eligibility for the employer contribution.

(c) If an employee's employing agency, or contracted vendor accepting forms directly, does not receive the required forms within thirty-one days of the employee regaining eligibility, the employee's enrollment ((~~in PEBB insurance coverage~~)) for those elections not received will be as described in subsection (1)(b)(i) through ((~~(iv) and (vi)~~))

(vii) of this section, except as described in (a)(i) and (b) of this subsection.

(d) If an employee is eligible to participate in the salary reduction plan (see WAC 182-12-116) the employee may enroll in the medical FSA or DCAP or both, except as limited by subsection (4) of this section. To enroll in these ((~~supplemental~~)) PEBB benefits, the employee must return the required form to the contracted vendor or their state agency. The contracted vendor or employee's state agency must receive the form no later than thirty-one days after the employee becomes eligible for PEBB benefits.

(4) If an employee who is eligible to participate in the salary reduction plan (see WAC 182-12-116) is hired into a new position that is eligible for PEBB benefits in the same year, the employee may not resume participation in DCAP or medical FSA until the beginning of the next plan year, unless the time between employments is thirty days or less and within the current plan year. The employee must notify their new state agency of the transfer by providing the new state agency's personnel, payroll, or benefits office the required form no later than thirty-one days after the employee's first day of work with the new state agency.

(5) An employee's PEBB ((~~insurance coverage~~)) benefits elections remain the same when an employee transfers from one employing agency to another employing agency without a break in PEBB ((~~insurance coverage~~)) benefits for one month or more. This includes movement of an employee between any entities described in WAC 182-12-111 and participating in PEBB benefits. PEBB ((~~insurance coverage~~)) benefits elections also remain the same when an employee has a break in employment that does not interrupt their employer contribution toward PEBB ((~~insurance coverage~~)) benefits.

WSR 20-13-075
PROPOSED RULES
HEALTH CARE AUTHORITY
(Public Employees Benefits Board)

[Admin # 2020-02—Filed June 16, 2020, 8:12 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 20-09-118.

Title of Rule and Other Identifying Information: **The following sections in chapter 182-12 WAC are revised:** WAC 182-12-171 When is a retiring employee or a retiring school employee eligible to enroll in public employees benefits board (PEBB) retiree insurance coverage?, 182-12-180 When is an elected and full-time appointed official of the legislative and executive branch of state government, or their survivor eligible to continue enrollment in public employees benefits board (PEBB) retiree insurance coverage?, 182-12-200 May a retiring employee, a retiring school employee, or a retiree enrolled as a dependent in a health plan sponsored by public employees benefits board (PEBB), a Washington state educational service district, or school employees benefits board (SEBB) defer enrollment under PEBB retiree insurance coverage?, 182-12-205 May a retiree or a survivor defer enrollment or voluntarily terminate enrollment under public employees benefits board (PEBB) retiree insurance coverage?, 182-12-211 May an employee or a school employee who is determined to be retroactively eligible for disability retirement enroll or defer enrollment in public employees benefits board (PEBB) retiree insurance coverage?, and 182-12-265 What options for continuing health plan enrollment are available to a surviving spouse, state registered domestic partner, or child, if an employee, a school employee, or a retiree dies?

Hearing Location(s): On July 21, 2020, at 10:00 a.m.

As more counties move into Phase 2 of the Governor's Safe Start plan, it is yet unknown whether by the date of this public hearing restrictions of meeting in public places will be eased. Therefore, this hearing is being held virtually only. This will not be an in-person hearing and there is not a physical location available.

You must register for this public hearing on July 21, 2020, 10:00 a.m. PDT at https://attendee.gotowebinar.com/register/6074456904428252685.

After registering, you will receive a confirmation email containing information about joining the webinar.

Date of Intended Adoption: Not sooner than July 22, 2020.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, by July 21, 2020.

Assistance for Persons with Disabilities: Contact Amber Lougheed, phone 360-725-1349, fax 360-586-9727, telecommunications relay services 711, email amber.lougheed@hca.wa.gov, by July 10, 2020.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The purpose of this proposal is to amend some of the existing rules to support the PEBB program.

1. Implement PEBB Policy Resolution 2020-05:

- Amended WAC 182-12-171, 182-12-180, 182-12-200, 182-12-205, 182-12-211, and 182-12-265 to implement if a subscriber selects a PEBB program medicare advantage-prescription drug (MAPD) plan, any non-medicare enrollees on the account will be enrolled in the uniform medical plan (UMP) classic.

2. Make technical amendments:

- Amended WAC 182-12-171, 182-12-180, 182-12-200, 182-12-205, 182-12-211, and 182-12-265 to include enrollment requirements for the medicare advantage (MA) and MAPD plans;
- Amended WAC 182-12-171, 182-12-180, 182-12-200, 182-12-205, and 182-12-265 to clarify the use of PEBB retiree insurance coverage and PEBB benefits;
- Amended WAC 182-12-171 and 182-12-180 to clarify enrollment requirements for those who are eligible for medicare to maintain enrollment in both medicare Parts A and B;
- Amended WAC 182-12-171 to clarify substantive eligibility requirements for an employee and a school employee, to clarify an exception for a retiring employee under a retirement plan sponsored by an employer group

or tribal government that is not sponsored by Washington state, and to clarify when the enrollee's eligibility will end;
- Amended WAC 182-12-180 to clarify the surviving spouse, state-registered domestic partner, or child of an official must meet procedural requirements to enroll and defer enrollment in PEBB retiree insurance coverage, and to clarify when the enrollee's eligibility will end;
- Amended WAC 182-12-200 to clarify a retiring employee or a retiring school employee may defer PEBB retiree insurance coverage if they meet substantive eligibility requirements, to clarify a retiring employee, a retiring school employee, or a retiree who defers enrollment in PEBB retiree insurance coverage, defers both PEBB medical and PEBB dental and they may later enroll themselves and their dependents;
- Amended WAC 182-12-200 and 182-12-205 to clarify a retiree may only defer enrollment in PEBB retiree term life insurance as described in WAC 182-12-209 (3)(b);
- Amended WAC 182-12-205 to include a WAC reference for the definition of creditable coverage.

Reasons Supporting Proposal: See purpose statement.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160, PEBB Policy Resolution 2020-05.

Statute Being Implemented: RCW 41.05.021, 41.05.160.

Rule is necessary because of federal law, 42 C.F.R. § 422.62(b) and 423.38(c).

Name of Proponent: Health care authority (HCA), governmental.

Name of Agency Personnel Responsible for Rob Parkman, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-0883; Implementation: Barbara Scott, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-0830; and Enforcement: Scott Palafox, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-1858.

A school district fiscal impact statement is not required under RCW 28A.305.135.

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

The proposed rule does not impose more-than-minor costs on businesses. Following is a summary of the agency's analysis showing how costs were calculated. These rules do not apply to small businesses.

June 16, 2020
Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-12-171 When is a retiring employee or a retiring school employee eligible to enroll in public employees benefits board (PEBB) retiree insurance coverage? A retiring employee or a retiring school employee is eligible to continue enrollment or defer enrollment in public employees benefits board (PEBB) insurance coverage as a retiree if they meet procedural and substantive eligibility requirements as described in subsections (1), (2), and (3) of this section. An elected and full-time appointed official of the legislative and executive branch of state government is eligible as described in WAC 182-12-180.

(1) **Procedural requirements.** A retiring employee or a retiring school employee must enroll or defer enrollment in PEBB retiree insurance coverage as described in (a) through (d) of this subsection:

(a) To enroll in PEBB retiree insurance coverage, the required form must be received by the PEBB program no later than sixty days after the employee's or the school employee's employer-paid coverage, Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage, or continuation coverage ends. The effective date of PEBB retiree insurance coverage is the first day of the month after the employee's or the school employee's employer-paid coverage, COBRA coverage, or continuation coverage ends;

Exception: Enrollment in the PEBB program's medicare advantage or medicare advantage-prescription drug plan may not be retroactive so the required forms must be received by the PEBB program no later than the last day of the month prior to the month the employee's or the school employee's employer-paid, COBRA coverage, or continuation coverage ends. If the forms are received after the date enrollment in PEBB retiree insurance coverage is to begin, a retiring employee or a retiring school employee may not select a medicare advantage or medicare advantage-prescription drug plan until a special enrollment period as described in WAC 182-08-198(2).

(b) The employee's or the school employee's first premium payment for PEBB retiree insurance coverage ((~~enrollment~~)) and applicable premium surcharges are due to the health care authority (HCA) no later than forty-five days after the election period ends as described in (a) of this subsection. Following the employee's or the school employee's first premium payment, premiums and applicable premium surcharges must be paid as described in WAC 182-08-180 (1)(c); and

(c) If a retiring employee or a retiring school employee elects to enroll a dependent in PEBB health plan coverage, the dependent must be enrolled in the same PEBB medical and PEBB dental plan as the retiring employee or the retiring school employee;

Exception: If a retiring employee or a retiring school employee selects a medicare supplement plan or medicare advantage-prescription drug plan, nonmedicare enrollees will be enrolled in the Uniform Medical Plan (UMP) Classic. If a retiring employee or a retiring school employee selects any other medicare plan, they must also select a nonmedicare plan with the same contracted vendor available to nonmedicare enrollees.

(d) To defer enrollment in ((~~a~~)) PEBB ((~~health plan~~)) retiree insurance coverage, the employee or the school employee must meet substantive eligibility requirements in subsection (2) of this section and defer enrollment as described in WAC 182-12-200 or 182-12-205.

(2) **Substantive eligibility requirements.**

((~~(a)~~)) An employee who is eligible for PEBB benefits through an employing agency, or a school employee who is eligible for SEBB benefits through a SEBB organization or basic benefits through an educational service district as

defined in RCW 28A.400.270 ((~~and~~)) who ends public employment ((~~after becoming vested in a Washington state-sponsored retirement plan~~)) may enroll or defer enrollment in PEBB retiree insurance coverage if they meet procedural and substantive eligibility requirements.

To be eligible to continue enrollment or defer enrollment in PEBB retiree insurance coverage ((~~as a retiree~~)), the employee or the school employee must be vested in and eligible to retire under a Washington state-sponsored retirement plan when the employee's or school employee's employer-paid coverage, COBRA coverage, or continuation coverage ends. An exception to the requirement to be vested in and eligible to retire under a Washington state-sponsored retirement plan is provided for employees of an employer group in (c)(i) of this subsection.

(((~~b~~))) (a) A retiring employee of a state agency must immediately begin to receive a monthly retirement plan payment, with exceptions described below:

(i) A retiring employee who receives a lump sum payment instead of a monthly retirement plan payment is only eligible if the department of retirement systems offered the employee the choice between a lump sum actuarially equivalent payment and the ongoing monthly payment, as allowed by the plan; or

(ii) A retiring employee who is a member of a Plan 3 retirement plan, also called a separated employee (defined in RCW 41.05.011(25)), must meet their Plan 3 retirement eligibility criteria. The employee does not have to receive a retirement plan payment to enroll in PEBB retiree insurance coverage.

(((~~c~~))) (b) A retiring employee of a Washington higher education institution who is a member of a higher education retirement plan (HERP) must immediately begin to receive a monthly retirement plan payment, or meet their HERP plan's retirement eligibility criteria, or be at least age fifty-five with ten years of state service;

(((~~d~~))) (c) A retiring employee of an employer group participating in PEBB insurance coverage under contractual agreement with the authority must be eligible to retire as described in (c)(i) or (ii) of this subsection to be eligible to continue PEBB retiree insurance coverage ((~~as a retiree~~)), except for an educational service district employee who must meet the requirements as described in ((~~subsection (2)(c)~~)) (d) of this ((~~section~~)) subsection.

(i) A retiring employee who is eligible to retire under a retirement plan sponsored by an employer group or tribal government that is not a Washington state-sponsored retirement plan must meet the same age and years of service requirements as if they were a member of public employees retirement system Plan 1, if their date of hire with that employer group or tribal government was before October 1, 1977, or Plan 2 ((~~during their employment~~)), if their date of hire with that employer group or tribal government was on or after October 1, 1977.

(ii) A retiring employee who is eligible to retire under a Washington state-sponsored retirement plan must immediately begin to receive a monthly retirement plan payment, with exceptions described in ((~~subsection (2)(b)~~)) (a)(i) and (ii) of this ((~~section~~)) subsection.

(iii) A retired employee of an employer group, except a Washington state educational service district, that ends participation in PEBB insurance coverage is no longer eligible to continue enrollment in PEBB retiree insurance coverage if they enrolled after September 15, 1991. Any retiree who loses eligibility for this reason may continue health plan enrollment as described in WAC 182-12-146.

(iv) A retired employee of a tribal government employer that ends participation in PEBB insurance coverage is no longer eligible to continue enrollment in PEBB retiree insurance coverage. Any retiree who loses eligibility for this reason may continue health plan enrollment as described in WAC 182-12-146.

(((~~c~~))) (d) A retiring school employee must immediately begin to receive a monthly retirement plan payment, with exceptions described below:

(i) A retiring school employee who ends employment before October 1, 1993; or

(ii) A retiring school employee who receives a lump sum payment instead of a monthly retirement plan payment is only eligible if the department of retirement systems offered the school employee the choice between a lump sum actuarially equivalent payment and the ongoing monthly payment, as allowed by the plan, or the school employee enrolled before 1995; or

(iii) A retiring school employee who is a member of a Plan 3 retirement system, also called a separated employee (defined in RCW 41.05.011(25)), must meet their Plan 3 retirement eligibility criteria; or

(iv) A school employee who retired as of September 30, 1993, and began receiving a monthly retirement plan payment from a Washington state-sponsored retirement system (as defined in chapters 41.32, 41.35 or 41.40 RCW) is eligible if they enrolled in a PEBB health plan no later than the HCA's annual open enrollment period for the year beginning January 1, 1995.

(3) A retiring employee or a retiring school employee and their enrolled dependents who are ((~~entitled to~~)) eligible for medicare must enroll and maintain enrollment in both medicare Parts A and B if the employee or the school employee retired after July 1, 1991. If a retiree or an enrolled dependent becomes ((~~entitled to~~)) eligible for medicare after enrollment in PEBB retiree insurance coverage, they must enroll and maintain enrollment in medicare Parts A and B to remain enrolled in a PEBB retiree health plan. If an enrollee who is ((~~entitled to~~)) eligible for medicare does not meet this procedural requirement, the enrollee is no longer eligible for enrollment in a PEBB retiree health plan. The enrollee's eligibility will end as described in the termination notice sent by the PEBB program. The enrollee may continue PEBB health plan enrollment as described in WAC 182-12-146.

Note: For the exclusive purpose of medicare Part A as described in this subsection, "eligible" means the enrollee is eligible for medicare Part A without a monthly premium.

(4) Washington state-sponsored retirement plans include:

(a) Higher education retirement plans;

(b) Law enforcement officers' and firefighters' retirement system;

(c) Public employees' retirement system;

(d) Public safety employees' retirement system;
(e) School employees' retirement system;
(f) State judges/judicial retirement system;
(g) Teachers' retirement system; and
(h) State patrol retirement system.
(i) The two federal retirement systems, Civil Service Retirement System and Federal Employees' Retirement System, are considered Washington state-sponsored retirement systems for Washington State University Extension for an employee covered under PEBB ((~~insurance coverage~~)) benefits at the time of retirement.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-12-180 When is an elected and full-time appointed official of the legislative and executive branch of state government, or their survivor eligible to continue enrollment in public employees benefits board (PEBB) retiree insurance coverage? (1) An elected and full-time appointed official of the legislative and executive branch of state government is eligible to continue enrollment or defer enrollment in public employees benefits board (PEBB) retiree insurance coverage under the same terms as an outgoing legislator, when they voluntarily or involuntarily leave public office. The following officials are eligible if they meet the procedural requirements as described in subsection (3) of this section:
(a) A member of the state legislature;
(b) A statewide elected official of the executive branch;
(c) An executive official appointed directly by the governor as the single head of an executive branch agency; or
(d) An official appointed directly by a state legislative committee as the single head of a legislative branch agency or an official appointed to secretary of the senate or chief clerk of the house of representatives.
(2) The spouse, state registered domestic partner, or child of an official described in subsection (1) of this section who loses eligibility due to the death of the official may enroll ((~~or defer enrollment~~)) as a survivor under PEBB retiree insurance coverage as described in (a) and (b) of this subsection and must meet procedural requirements to enroll or defer enrollment as described in subsection (3) of this section.
(a) The official's spouse or state registered domestic partner may continue health plan enrollment until death.
(b) The official's child may continue health plan enrollment until they lose eligibility as described in WAC 182-12-260.
(3) **Procedural requirements.** An official described in subsection (1) of this section or their survivor described in subsection (2) of this section must enroll or defer enrollment in PEBB retiree insurance coverage as described in (a) through (d) of this subsection:
(a) For an official to enroll in PEBB retiree insurance coverage the required forms must be received by the PEBB program no later than sixty days after the official leaves public office. The effective date of PEBB retiree insurance coverage is the first day of the month after the official leaves public office;

For a survivor to enroll in PEBB retiree insurance coverage, the required forms must be received by the PEBB program no later than sixty days after the later of the date of the official's death or the date the survivor's PEBB insurance coverage ends. The effective date of PEBB retiree insurance coverage is the first day of the month after the date of the official's death or the first day of the month after the survivor's PEBB insurance coverage ends;

Exception: Enrollment in the PEBB program's medicare advantage or medicare advantage-prescription drug plan may not be retroactive so the required forms must be received by the PEBB program before the official leaves public office or no later than the last day of the month prior to the month PEBB insurance coverage ends. If the forms are received after the date enrollment in PEBB retiree insurance coverage is to begin, the subscriber may not select a medicare advantage or medicare advantage-prescription drug plan until a special enrollment period as described in WAC 182-08-198(2).

(b) The official's or survivor's first premium payment and applicable premium surcharges are due to the health care authority (HCA) no later than forty-five days after the official's or survivor's election period ends as described in (a) of this subsection. Following the official's or survivor's first premium payment, premiums and applicable premium surcharges must be paid as described in WAC 182-08-180 (1)(c);
(c) If an official or a survivor elects to enroll a dependent in PEBB health plan coverage, the dependent must be enrolled in the same PEBB medical and PEBB dental plan as the official or survivor;

Exception: If an official or a survivor selects a medicare supplement plan or medicare advantage-prescription drug plan, nonmedicare enrollees will be enrolled in the Uniform Medical Plan (UMP) Classic. If an official or a survivor selects any other medicare plan, they must also select a nonmedicare plan with the same contracted vendor available to nonmedicare enrollees.

(d) To defer enrollment in ((~~a~~)) PEBB ((~~health plan~~)) retiree insurance coverage the official or the survivor must meet deferral enrollment requirements as described in WAC 182-12-200 or 182-12-205.
(4) If the official, an enrolled dependent, or their survivor is ((~~entitled to~~)) eligible for medicare or becomes ((~~entitled to~~)) eligible for medicare after enrollment in PEBB retiree insurance coverage, they must enroll and maintain enrollment in medicare Parts A and B to remain enrolled in a PEBB retiree health plan. If an enrollee who is ((~~entitled to~~)) eligible for medicare does not meet this procedural requirement, the enrollee is no longer eligible for enrollment in a PEBB retiree health plan. The enrollee's eligibility will end as described in the termination notice sent by the PEBB program. The enrollee may continue PEBB health plan enrollment as described in WAC 182-12-146.

Note: For the exclusive purpose of medicare Part A as described in this subsection, "eligible" means the enrollee is eligible for medicare Part A without a monthly premium.

(5) An official described in subsection (1) of this section shall be included in the term "retiree" or "retiring employee" as used in chapters 182-08, 182-12, and 182-16 WAC.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-12-200 May a retiring employee, a retiring school employee, or a retiree enrolled as a dependent in a health plan sponsored by public employees benefits board (PEBB), a Washington state educational service district, or school employees benefits board (SEBB) defer ((~~PEBB health plan~~)) enrollment under PEBB retiree insurance coverage? (1) A retiring employee or a retiring school employee may defer enrollment in ((~~a~~)) public employees benefits board (PEBB) ((~~health plan~~)) retiree insurance coverage at retirement ((~~or~~)) if they meet substantive eligibility requirements as described in WAC 182-12-171(2) or as described in WAC 182-12-180(1). An enrolled retiree may defer enrollment after enrolling in PEBB retiree insurance coverage. Enrollment in ((~~a~~)) PEBB ((~~health plan~~)) retiree insurance coverage may be deferred when they are enrolled as a dependent in a health plan sponsored by PEBB, a Washington state educational service district, or ((~~SEBB~~)) school employees benefits board (SEBB), including such coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or continuation coverage. ((~~A retiring employee or a retiring school employee who defers enrollment at retirement must meet substantive eligibility requirements as described in WAC 182-12-171(2) or requirements as described in WAC 182-12-180(1).~~))

(2) A retiring employee, a retiring school employee, or a retiree who defers enrollment in ((~~medical must~~)) PEBB retiree insurance coverage defers enrollment in PEBB medical and PEBB dental. A retiree((~~s~~)) must be enrolled in PEBB medical to enroll in PEBB dental. A retiree who defers enrollment ((~~in a PEBB health plan~~)) also defers enrollment for all eligible dependents. A retiree may only defer enrollment in PEBB retiree term life insurance as described in WAC 182-12-209 (3)(b).

(3) A retiring employee, a retiring school employee, or a retiree who defers enrollment may later enroll themselves and their dependents in a PEBB health plan if they provide evidence of continuous enrollment in a health plan sponsored by PEBB, a Washington state educational service district, or SEBB, and submits the required form as described in (a) and (b) of this subsection:

(a) During the PEBB annual open enrollment period. The required form must be received by the PEBB program no later than the last day of the open enrollment period. PEBB health plan coverage begins January 1st of the following year; or

(b) When enrollment in a health plan sponsored by PEBB, a Washington state educational service district, or SEBB ends, or such coverage under COBRA or continuation coverage ends. The required forms to enroll must be received by the PEBB program no later than sixty days after coverage ends. PEBB health plan coverage begins the first day of the month following the date the other coverage ends. To continue in a deferred status, the retiree must defer enrollment as described in WAC 182-12-205.

Exception: Enrollment in the PEBB program's medicare advantage or medicare advantage-prescription drug plan may not be retroactive so the required forms and evidence of continuous enrollment must be received by the PEBB program no later than the last day of the month prior to the month the other coverage ends. If the forms are received after the date enrollment in PEBB retiree insurance coverage is to begin, the subscriber may not select a medicare advantage or medicare advantage-prescription drug plan until a special enrollment period as described in WAC 182-08-198(2).

(((~~(4)~~))) (c) If a retiree elects to enroll a dependent in PEBB health plan coverage as described in this subsection, the dependent must be enrolled in the same PEBB medical or PEBB dental plan as the retiree.

Exception: If a retiree selects a medicare supplement plan or medicare advantage-prescription drug plan, nonmedicare enrollees will be enrolled in the Uniform Medical Plan (UMP) Classic. If a retiree selects any other medicare plan, they must also select a nonmedicare plan with the same contracted vendor available to nonmedicare enrollees.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-12-205 May a retiree or a survivor defer enrollment or voluntarily terminate enrollment under public employees benefits board (PEBB) ((~~health plan enrollment under PEBB~~)) retiree insurance coverage? (1) The following individuals may defer enrollment in ((~~a~~)) public employees benefits board (PEBB) ((~~health plan~~)) retiree insurance coverage:

(a) A retiring employee or a retiring school employee;

(b) A dependent becoming eligible as a survivor; or

(c) A retiree or a survivor enrolled in PEBB retiree insurance coverage.

(2) A subscriber described in subsection (1) of this section who defers enrollment in ((~~a~~)) PEBB ((~~health plan~~)) retiree insurance coverage also defers enrollment for all eligible dependents, except as described in subsection (3)(c) of this section.

(3) A subscriber described in subsection (1) of this section who chooses to defer((~~s~~)) enrollment in ((~~a~~)) PEBB ((~~health plan~~)) retiree insurance coverage must maintain continuous enrollment in other medical as described in this section or WAC 182-12-200. A subscriber who chooses to defer((~~s~~)) enrollment, defers enrollment in PEBB medical ((~~must defer enrollment in~~)) and PEBB dental. A subscriber must be enrolled in PEBB medical to enroll in PEBB dental. A retiree may only defer enrollment in PEBB retiree term life insurance as described in WAC 182-12-209 (3)(b).

(a) Beginning January 1, 2001, enrollment in ((~~a~~)) PEBB ((~~health plan~~)) retiree insurance coverage may be deferred when the subscriber is enrolled in employer-based group medical as an employee or the dependent of an employee, or such medical insurance continued under Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage or continuation coverage.

(b) Beginning January 1, 2001, enrollment in ((~~a~~)) PEBB ((~~health plan~~)) retiree insurance coverage may be deferred

when the subscriber is enrolled as a retiree or the dependent of a retiree in a federal retiree medical plan.

(c) Beginning January 1, 2006, enrollment in ((~~a~~)) PEBB ((~~health plan~~)) retiree insurance coverage may be deferred when the subscriber is enrolled in medicare Parts A and B and a medicaid program that provides creditable coverage as ((~~described~~)) defined in ((~~this chapter~~)) WAC 182-12-109. Dependents may continue their PEBB health plan enrollment if they meet PEBB eligibility criteria and are not eligible for creditable coverage under a medicaid program.

(d) Beginning January 1, 2014, subscribers who are not eligible for Parts A and B of medicare may defer enrollment in ((~~a~~)) PEBB ((~~health plan~~)) retiree insurance coverage when the subscriber is enrolled in exchange coverage.

(e) Beginning July 17, 2018, enrollment in ((~~a~~)) PEBB ((~~health plan~~)) retiree insurance coverage may be deferred when the subscriber is enrolled in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).

(4) To defer enrollment in PEBB ((~~health plan enrollment~~)) retiree insurance coverage, the required forms must be submitted to the PEBB program.

(a) For a retiring employee or a retiring school employee who meets the substantive eligibility requirements as described in WAC 182-12-171(2), enrollment will be deferred the first of the month following the date their employer-paid coverage, COBRA coverage, or continuation coverage ends. The forms must be received by the PEBB program no later than sixty days after the employer-paid coverage, COBRA coverage, or continuation coverage ends.

(b) For an official leaving public office who meets the requirements as described in WAC 182-12-180(1), enrollment will be deferred the first of the month following the date the official leaves public office. The forms must be received by the PEBB program no later than sixty days after the official leaves public office.

(c) For an employee or a school employee determined to be retroactively eligible for disability retirement who meets the requirements as described in WAC 182-12-211 (1)(a) through (c), enrollment will be deferred as described in WAC 182-12-211 (2) or (3). The forms and formal determination letter must be received by the PEBB program no later than sixty days after the date on the determination letter.

(d) For an eligible survivor, the dependent must meet the requirements described below and the forms must be received by the PEBB program within the time described:

(i) For a survivor of an employee or a school employee who meets the requirements as described in WAC 182-12-265 (1) or (3), enrollment will be deferred the first of the month following the later of the date of the employee's or the school employee's death or the date the survivor's PEBB insurance coverage, educational service district coverage, or school employees benefits board (SEBB) insurance coverage ends. The forms must be received by the PEBB program no later than sixty days after the later of the date of the employee's or the school employee's death or the date the survivor's PEBB insurance coverage, educational service district coverage, or SEBB insurance coverage ends.

(ii) For a survivor of an official who meets the requirements as described in WAC 182-12-180(2), enrollment will be deferred the first of the month following the later of the date of the official's death or the date the survivor's PEBB insurance coverage ends. The forms must be received by the PEBB program no later than sixty days after the later of the date of the official's death or the date the survivor's PEBB insurance coverage ends.

(iii) For a survivor of a retiree who meets the requirements as described in WAC 182-12-265(2), enrollment will be deferred the first of the month following the date of the retiree's death. The forms must be received by the PEBB program no later than sixty days after the retiree's death.

(iv) For a survivor of an emergency service personnel killed in the line of duty who meets the requirements as described in WAC 182-12-250, enrollment will be deferred the first of the month following the later of one of the events described in WAC 182-12-250 (5)(a) through (d). The forms must be received by the PEBB program no later than one hundred eighty days after the later of one of the events described in WAC 182-12-250 (5)(a) through (d).

(e) For an enrolled retiree or survivor who submits the required forms to defer enrollment in ((~~a~~)) PEBB ((~~health plan~~)) retiree insurance coverage, enrollment will be deferred effective the first of the month following the date the required forms are received by the PEBB program. If the forms are received on the first day of the month, enrollment will be deferred effective that day.

Exception: When a subscriber or their dependent is enrolled in a medicare advantage plan, then enrollment in ((~~a~~)) PEBB ((~~health plan~~)) retiree insurance coverage will be deferred effective the first of the month following the date the medicare advantage plan disenrollment form is received.

(5) A retiree who meets substantive eligibility requirements in WAC 182-12-171(2) and whose employer-paid coverage, COBRA coverage, or continuation coverage ended between January 1, 2001, and December 31, 2001, was not required to have submitted the deferral form at that time, but must meet all procedural requirements as stated in this section, WAC 182-12-171, and 182-12-200.

(6) A subscriber described in subsection (1) of this section who defers enrollment while enrolled in qualifying coverage as described in subsection (3)(a) through (e) of this section may later enroll themselves and their dependents in a PEBB health plan by submitting the required forms as described below and evidence of continuous enrollment in one or more qualifying coverages as described in subsection (3)(a) through (e) of this section:

(a) A subscriber who defers enrollment while enrolled in employer-based group medical or such medical insurance continued under COBRA coverage or continuation coverage may enroll in a PEBB health plan by submitting the required forms and evidence of continuous enrollment to the PEBB program:

(i) During the PEBB annual open enrollment period. The required forms must be received by the PEBB program no later than the last day of the open enrollment period. PEBB health plan coverage begins January 1st of the following year; or

(ii) When their employer-based group medical or such coverage under COBRA coverage or continuation coverage

ends. The required forms and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after coverage ends. PEBB health plan coverage begins the first day of the month after the employer-based group medical coverage, COBRA coverage, or continuation coverage ends.

Exception: Enrollment in the PEBB program's medicare advantage or medicare advantage-prescription drug plan may not be retroactive so the required forms and evidence of continuous enrollment must be received by the PEBB program no later than the last day of the month prior to the month the employer-based group medical, COBRA coverage, or continuation coverage ends. If the forms are received after the date enrollment in PEBB retiree insurance coverage is to begin, the subscriber may not select a medicare advantage or medicare advantage-prescription drug plan until a special enrollment period as described in WAC 182-08-198(2).

(b) A subscriber who defers enrollment while enrolled as a retiree or dependent of a retiree in a federal retiree medical plan will have a one-time opportunity to enroll in a PEBB health plan by submitting the required forms and evidence of continuous enrollment to the PEBB program:

(i) During the PEBB annual open enrollment period. The required forms must be received by the PEBB program no later than the last day of the open enrollment period. PEBB health plan coverage begins January 1st of the following year; or

(ii) When the federal retiree medical plan coverage ends. The required forms and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after coverage ends. PEBB health plan coverage begins the first day of the month after coverage under the federal retiree medical plan ends.

Exception: Enrollment in the PEBB program's medicare advantage or medicare advantage-prescription drug plan may not be retroactive so the required forms and evidence of continuous enrollment must be received by the PEBB program no later than the last day of the month prior to the month the federal retiree medical plan coverage ends. If the forms are received after the date enrollment in PEBB retiree insurance coverage is to begin, the subscriber may not select a medicare advantage or medicare advantage-prescription drug plan until a special enrollment period as described in WAC 182-08-198(2).

(c) A subscriber who defers enrollment while enrolled in medicare Parts A and B and a medicaid program that provides creditable coverage as ((~~described~~)) defined in ((~~this chapter~~)) WAC 182-12-109 may enroll in a PEBB health plan by submitting the required forms and evidence of continuous enrollment to the PEBB program:

(i) During the PEBB annual open enrollment period. The required forms must be received by the PEBB program no later than the last day of the open enrollment period. PEBB health plan coverage begins January 1st of the following year; or

(ii) When their medicaid coverage ends. The required forms and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after coverage ends. PEBB health plan coverage begins the first day of the month after the medicaid coverage ends; or

Exception: Enrollment in the PEBB program's medicare advantage or medicare advantage-prescription drug plan may not be retroactive so the required forms and evidence of continuous enrollment must be received by the PEBB program no later than the last day of the month prior to the month medicaid coverage ends. If the forms are received after the date enrollment in PEBB retiree insurance coverage is to begin, the subscriber may not select a medicare advantage or medicare advantage-prescription drug plan until a special enrollment period as described in WAC 182-08-198(2).

(iii) No later than the end of the calendar year when their medicaid coverage ends if the retiree or survivor was also determined eligible under 42 U.S.C. § 1395w-114 and subsequently enrolled in a medicare Part D plan. Enrollment in the PEBB health plan will begin January 1st following the end of the calendar year when the medicaid coverage ends. The required forms must be received by the PEBB program no later than the last day of the calendar year in which the medicaid coverage ends.

(d) A subscriber who defers enrollment while enrolled in exchange coverage will have a one-time opportunity to enroll or reenroll in a PEBB health plan by submitting the required forms and evidence of continuous enrollment to the PEBB program:

(i) During the PEBB annual open enrollment period. The required forms must be received by the PEBB program no later than the last day of the open enrollment period. PEBB health plan coverage begins January 1st of the following year; or

(ii) When exchange coverage ends. The required forms and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after coverage ends. PEBB health plan coverage begins the first day of the month after exchange coverage ends.

Exception: Enrollment in the PEBB program's medicare advantage or medicare advantage-prescription drug plan may not be retroactive so the required forms and evidence of continuous enrollment must be received by the PEBB program no later than the last day of the month prior to the month exchange coverage ends. If the forms are received after the date enrollment in PEBB retiree insurance coverage is to begin, the subscriber may not select a medicare advantage or medicare advantage-prescription drug plan until a special enrollment period as described in WAC 182-08-198(2).

(e) A subscriber who defers enrollment while enrolled in CHAMPVA will have a one-time opportunity to enroll in a PEBB health plan by submitting the required forms and evidence of continuous enrollment to the PEBB program:

(i) During the PEBB annual open enrollment period. The required forms must be received by the PEBB program no later than the last day of the open enrollment period. PEBB health plan coverage begins January 1st of the following year; or

(ii) When CHAMPVA coverage ends. The required forms and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after coverage ends. PEBB health plan coverage begins the first day of the month after CHAMPVA coverage ends.

Exception: Enrollment in the PEBB program's medicare advantage or medicare advantage-prescription drug plan may not be retroactive so the required forms and evidence of continuous enrollment must be received by the PEBB program no later than the last day of the month prior to the month CHAMPVA coverage ends. If the forms are received after the date enrollment in PEBB retiree insurance coverage is to begin, the subscriber may not select a medicare advantage or medicare advantage-prescription drug plan until a special enrollment period as described in WAC 182-08-198(2).

(f) A subscriber who defers enrollment may enroll in a PEBB health plan if they receive formal notice that the authority has determined it is more cost-effective to enroll them or their eligible dependents in PEBB medical than a medical assistance program.

(g) If a subscriber elects to enroll a dependent in PEBB health plan coverage as described in this subsection, the dependent must be enrolled in the same PEBB medical and PEBB dental plan as the subscriber.

Exception: If a subscriber selects a medicare supplement plan or medicare advantage-prescription drug plan, nonmedicare enrollees will be enrolled in the Uniform Medical Plan (UMP) Classic. If a subscriber selects any other medicare plan, they must also select a nonmedicare plan with the same contracted vendor available to nonmedicare enrollees.

(7) An enrolled retiree or a survivor who requests to voluntarily terminate their enrollment in ((~~a~~)) PEBB ((~~health plan~~)) retiree insurance coverage must do so in writing. The written termination request must be received by the PEBB program. A retiree or a survivor who voluntarily terminates their enrollment in a PEBB health plan also terminates enrollment for all eligible dependents. Once coverage is terminated, a retiree or a survivor may not enroll again in the future unless they reestablish eligibility for PEBB insurance coverage by becoming newly eligible. Enrollment in a PEBB health plan will terminate on the last day of the month in which the PEBB program receives the termination request. If the termination request is received on the first day of the month, enrollment ((~~in a PEBB health plan~~)) will terminate on the last day of the previous month.

Exception: When a subscriber or their dependent is enrolled in a medicare advantage plan, then enrollment ((~~in a PEBB health plan~~)) will terminate on the last day of the month when the medicare advantage plan disenrollment form is received.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-12-211 May an employee or a school employee who is determined to be retroactively eligible for disability retirement enroll or defer enrollment in public employees benefits board (PEBB) retiree insurance coverage? (1) An employee or a school employee who is determined to be retroactively eligible for a disability retirement is eligible to enroll or defer enrollment (as described in WAC 182-12-200 or 182-12-205) in public employees benefits board (PEBB) retiree insurance coverage if:

(a) The employee or the school employee submits the required form and a copy of the formal determination letter they received from the Washington state department of retirement systems (DRS) or the appropriate higher education authority;

(b) The employee's or the school employee's form and a copy of their Washington state-sponsored retirement system's formal determination letter are received by the PEBB program no later than sixty days after the date on the determination letter; and

(c) The employee or the school employee immediately begins to receive a monthly pension benefit or a supplemental retirement plan benefit under their higher education retirement plan (HERP), with exceptions described below from WAC 182-12-171(2):

(i) A retiring employee of a state agency, an employer group participating under a Washington state sponsored retirement plan, or a retiring school employee who receives a lump sum payment instead of a monthly retirement plan payment is only eligible if the department of retirement systems offered the employee the choice between a lump sum actuarially equivalent payment and the ongoing monthly payment, as allowed by the plan; or

(ii) A retiring employee of a state agency, an employer group participating under a Washington state sponsored retirement plan, or a retiring school employee who is a member of a Plan 3 retirement plan, also called a separated employee (defined in RCW 41.05.011(25)), must meet their Plan 3 retirement eligibility criteria. The employee or the school employee does not have to receive a retirement plan payment to enroll in PEBB retiree insurance coverage; or

(iii) A retiring employee of a Washington higher education institution who is a member of a higher education retirement plan (HERP) must immediately begin to receive a monthly retirement plan payment, or meet their HERP plan's retirement eligibility criteria, or be at least age fifty-five with ten years of state service.

(2) The employee or the school employee, at their option, must indicate the date of enrollment or deferment in PEBB retiree insurance coverage on the form. The employee or the school employee may choose from the following dates:

(a) The retirement date as stated in the formal determination letter; or

(b) The first day of the month following the date the formal determination letter was written.

Exception: Enrollment in the PEBB program's medicare advantage or medicare advantage-prescription drug plan may not be retroactive. The employee or the school employee may change health plans to a medicare advantage or medicare advantage-prescription drug plan during a special enrollment period as described in WAC 182-08-198(2).

(3) The director may make an exception to the date of PEBB retiree insurance coverage described in subsection (2) (a) and (b) of this section; however, such request must demonstrate extraordinary circumstances beyond the control of the retiree.

(4) Premiums and applicable premium surcharges are due from the effective date of enrollment in PEBB retiree insurance coverage.

(5) If a retiring employee or a retiring school employee elects to enroll a dependent in PEBB health plan coverage, the dependent must be enrolled in the same PEBB medical and PEBB dental plan as the retiring employee or the retiring school employee.

Exception: If a retiring employee or a retiring school employee selects a medicare supplement plan or medicare advantage-prescription drug plan, nonmedicare enrollees will be enrolled in the Uniform Medical Plan (UMP) Classic. If a retiring employee or a retiring school employee selects any other medicare plan, they must also select a nonmedicare plan with the same contracted vendor available to nonmedicare enrollees.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-12-265 What options for continuing health plan enrollment are available to a surviving spouse, state registered domestic partner, or child, if an employee, a school employee, or a retiree dies? The survivor of an eligible employee, an eligible school employee, or a retiree who meets the eligibility criteria and submits the required forms as described in subsection (1), (2), or (3) of this section is eligible to enroll or defer enrollment as a survivor under public employees benefits board (PEBB) retiree insurance coverage. If enrolling in PEBB retiree insurance coverage, the survivor's first premium payment and applicable premium surcharges are due to the health care authority (HCA) no later than forty-five days after the election period ends as described in subsection (1), (2), or (3) of this section. Following the survivor's first premium payment, premiums and applicable premium surcharges must be paid as described in WAC 182-08-180 (1)(c).

(1) An employee's spouse, state registered domestic partner, or child who loses eligibility due to the death of an eligible employee may enroll or defer enrollment as a survivor under PEBB retiree insurance coverage provided they immediately begin receiving a monthly retirement benefit from any state of Washington sponsored retirement system. To satisfy the requirement to immediately receive a monthly retirement benefit they must begin receiving monthly benefit payments no later than one hundred twenty days from the date of death of the employee. The required forms to enroll or defer enrollment must be received by the PEBB program no later than sixty days after the later of the date of the employee's death or the date the survivor's PEBB insurance coverage ends.

Exception: Enrollment in the PEBB program's medicare advantage or medicare advantage-prescription drug plan may not be retroactive so the required forms must be received by the PEBB program no later than the last day of the month prior to the month PEBB insurance coverage ends. If the forms are received after the date enrollment in PEBB retiree insurance coverage is to begin, the survivor may not select a medicare advantage or medicare advantage-prescription drug plan until a special enrollment period as described in WAC 182-08-198(2).

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

(b) The employee's children may continue health plan enrollment until they lose eligibility as described in WAC 182-12-260.

Notes: If a spouse, state registered domestic partner, or child of an eligible employee is not eligible for a monthly retirement benefit, they are not eligible to enroll as a survivor under PEBB retiree insurance coverage. However, they may continue health plan enrollment as described in WAC 182-12-146.

Eligibility for the surviving spouse, surviving state registered domestic partner, or surviving child of an employee of a participating employer group will cease at the end of the month in which the group's contract with the authority ends unless the employer group is an educational service district.

Eligibility for the surviving spouse, surviving state registered domestic partner, or surviving child of an elected and full-time appointed official of the legislative and executive branches of state government is described in WAC 182-12-180.

(2) A retiree's spouse, state registered domestic partner, or child who loses eligibility due to the death of an eligible retiree may enroll or defer enrollment as a survivor under PEBB retiree insurance coverage. The required forms to enroll or defer enrollment must be received by the PEBB program no later than sixty days after the retiree's death.

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

(b) The retiree's children may continue health plan enrollment until they lose eligibility as described in WAC 182-12-260.

(c) If a spouse, state registered domestic partner, or child of an eligible retiree is not enrolled in a PEBB health plan at the time of the retiree's death, the survivor is eligible to enroll or defer enrollment as a survivor under PEBB retiree insurance coverage. The required forms to enroll or defer enrollment must be received by the PEBB program no later than sixty days after the retiree's death. To enroll in a PEBB health plan, the survivor must provide evidence of continuous enrollment in medical coverage as described in WAC 182-12-205 from the most recent open enrollment for which the survivor was not enrolled in a PEBB medical plan prior to the retiree's death.

Note: Eligibility for the surviving spouse, surviving state registered domestic partner, or surviving child of an employer group retiree will cease at the end of the month in which the group's contract with the authority ends unless the employer group is an educational service district.

(3) A school employee's spouse, state registered domestic partner, or child who loses eligibility due to the death of an eligible school employee may enroll or defer enrollment as a survivor under PEBB retiree insurance coverage at the time of the school employee's death, provided the employee died on or after October 1, 1993. The survivor must immediately begin receiving a retirement benefit allowance under chapter 41.32, 41.35 or 41.40 RCW. The required forms to enroll or defer enrollment must be received by the PEBB program no later than sixty days after the later of the date of the school employee's death or the date the survivor's educational service district coverage, or school employees benefits board (SEBB) insurance coverage ends.

Exception: Enrollment in the PEBB program's medicare advantage or medicare advantage-prescription drug plan may not be retroactive so the required forms must be received by the PEBB program no later than the last day of the month prior to the month the educational service district coverage or SEBB insurance coverage ends. If the forms are received after the date enrollment in PEBB retiree insurance coverage is to begin, the survivor may not select a medicare advantage or medicare advantage-prescription drug plan until a special enrollment period as described in WAC 182-08-198(2).

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

(b) The school employee's children may continue health plan enrollment until they lose eligibility as described in WAC 182-12-260.

Note: If a spouse, state registered domestic partner, or child of an eligible school employee is not eligible for a retirement benefit allowance, they are not eligible to enroll as a survivor under PEBB retiree insurance coverage. However, a spouse, state registered domestic partner, or child of an eligible school employee enrolled in SEBB insurance coverage may continue health plan enrollment as described in WAC 182-31-090.

(4) If premiums and applicable premium surcharges received by the HCA are sufficient as described in WAC 182-08-180 (1)(d)(ii) to maintain PEBB health plan enrollment after the employee, school employee, or retiree's death, the PEBB program will consider the payment as notice of the survivor's intent to continue enrollment.

If the survivor's enrollment ended due to the death of the employee, school employee, or retiree, the PEBB program will reinstate the survivor's enrollment without a gap subject to payment of premium and applicable premium surcharges.

(5) If a survivor elects to enroll a dependent in PEBB health plan coverage, the dependent must be enrolled in the same PEBB medical and PEBB dental plan as the survivor.

Exception: If a survivor selects a medicare supplement plan or medicare advantage-prescription drug plan, nonmedicare enrollees will be enrolled in the Uniform Medical Plan (UMP) Classic. If a survivor selects any other medicare plan, they must also select a nonmedicare plan with the same contracted vendor available to nonmedicare enrollees.

(6) In order to avoid duplication of group medical coverage, a survivor may defer enrollment in ((~~a~~)) PEBB ((~~health plan~~)) retiree insurance coverage as described in WAC 182-12-200 and 182-12-205.

WSR 20-13-078
PROPOSED RULES
DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES

[Filed June 16, 2020, 10:22 a.m.]

Original Notice.

Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1).

Title of Rule and Other Identifying Information: Working connections and seasonal child care programs: WAC 110-15-0023 Homeless grace period (HGP), 110-15-0200 Daily child care rates—Licensed or certified child care centers and DCYF contracted seasonal day camps, and 110-15-0205 Daily child care rates—Licensed or certified family home child care providers.

Hearing Location(s): On July 21, 2020, telephonic.

Oral comments may be made by calling 360-902-8084 and leaving a voicemail that includes the comment and an email or physical mailing address where the department of children, youth, and families (DCYF) will send its response. Comments received through and including July 21 will be considered.

Date of Intended Adoption: July 22, 2020.

Submit Written Comments to: Rules Coordinator, P.O. Box 40975, email dcyf.rulescoordinator@dcyf.wa.gov, fax 360-902-7903, submit comments online at https://dcyf.wa.gov/practice/policy-laws-rules/rule-making/participate/online, by July 21, 2020.

Assistance for Persons with Disabilities: Contact DCYF Rules Coordinator, phone 360-902-7956, fax 360-902-7903, email dcyf.rulescoordinator@dcyf.wa.gov, by July 17, 2020.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Working connections child care (WCCC) provides child care subsidies for families who meet prescribed income thresholds and who are engaged in work or certain work activities. Homeless grace period: Families experiencing homelessness as verified by the department are allowed a grace period to meet program requirements, including providing verification of participation in work or approved work activities. Proposed WAC 110-15-0023 changes the grace period from four to twelve months. Rates: The department pays providers who care for children authorized for WCCC the lesser of the providers' private rates or rates codified in rule. Proposed WAC 110-15-0200 and 110-15-0205 increase rates for licensed and certified child care centers and family home child cares, respectively.

Reasons Supporting Proposal: Section 2, chapter 279, Laws of 2020 directs the department to extend the homeless grace period to twelve months. Rate increases are intended to bring subsidy rates closer to market rates as directed by section 225(4), chapter 357, Laws of 2020, and to improve access to subsidized child care by encouraging additional child cares to participate in WCCC.

Statutory Authority for Adoption: RCW 43.216.055 and 43.216.065.

Statute Being Implemented: Section 2, chapter 279 and section 225(4), chapter 357, Laws of 2020.

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

Name of Proponent: DCYF, governmental.

Name of Agency Personnel Responsible for Drafting: Jason Ramynke, Olympia, Washington, 360-668-0911; Implementation and Enforcement: DCYF, statewide.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. A cost-benefit analysis is not required under RCW

34.05.328. DCYF is not among the agencies listed as required to comply with RCW 34.05.328 (5)(i). DCYF does not voluntarily make that section applicable to the adoption of the proposed rules.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(3) as the rules relate only to internal governmental operations that are not subject to violation by a nongovernment party; and rules set or adjust fees under the authority of RCW 19.02.075 or that set or adjust fees or rates pursuant to legislative standards, including fees set or adjusted under the authority of RCW 19.80.045.

June 16, 2020
Brenda Villarreal
Rules Coordinator

AMENDATORY SECTION (Amending WSR 18-14-078, filed 6/29/18, effective 7/1/18)

WAC 110-15-0023 Homeless grace period (HGP). (1) ((~~Families experiencing homelessness will be eligible for HGP and will have a certification period of twelve months:~~

~~(a) When homelessness is verified within thirty days of the date of application or reapplication;~~

~~(b) When the family has not received HGP in the twelve calendar months prior to the month of application or reapplication; and~~

~~(c) When the family meets all eligibility requirements under WAC 170-290-0005 and 170-290-0030, except~~)) A homeless grace period (HGP) is established as described in this section.

(2) DCYF may grant a consumer experiencing homelessness a twelve-month grace period to submit the documentation described in this subsection. The children of the consumer experiencing homelessness may receive WCCC services during the HGP. Within twelve months of the child being authorized in the WCCC program, the consumer must submit to DCYF:

(i) Documentation verifying participation ((~~or participating~~)) in an approved ((~~activities in WAC 170-290-0040, 170-290-0045, 170-290-0050, or 170-290-0055; or~~

~~(ii) Providing required third-party verification of employment within thirty days of receipt of an application or reapplication; or~~

~~(iii) Having an outstanding copayment or not having a payment plan for the outstanding copayment.~~

~~(2) Families eligible for HGP will have a period of four months to provide:~~

~~(a) Verification of participation in approved activities in WAC 170-290-0040, 170-290-0045, 170-290-0050, or 170-290-0055;~~

~~(b) Required third-party verification of employment; and~~

~~(c) Verification of payment or payment plan arrangements for an outstanding copayment.~~

~~(3) Families must report changes as required in WAC 170-290-0031 and will remain eligible for HGP through the end of the fourth month, if their homeless status changes.~~

~~(4) If received in months one through four, the verification required in subsection (3) of this section will not need reverification for care to continue during months five through twelve.~~

~~(5) The four-month period begins on the first date of eligibility, which is the date of application or reapplication and the first month may be a partial month. The four-month period ends on the last day of the fourth month.~~

~~(6) Termination of HGP will occur on the last day of the fourth month if the family does not:~~

~~(a) Verify they have entered an approved activity;~~

~~(b) Provide the required third-party verification of employment;~~

~~(c) Pay or make payment arrangements of an outstanding copayment.~~

~~(7) DSHS will approve HGP for families using WCCC for the fourteen-day wait period (WAC 170-290-0055). If the family has verified their homeless status but not entered the approved activity by the fourteenth day:~~

~~(a) HGP is approved the first day following the end of the fourteen-day wait period instead of terminating WCCC;~~

~~(b) The copayment is waived effective the first day of the month following the last day of the fourteen-day wait period; and~~

~~(c) The copayment is waived for the remainder of the four-month period, even if it is less than four months.~~

~~(d) When homelessness is verified and HGP approved, an overpayment will not be established for the fourteen-day wait period.~~

~~(8) DSHS will approve HGP for families using WCCC for the sixty days of self-attestation of new employment (WAC 170-290-0012). If the family has verified their homeless status but not provided the required employment verification by the sixtieth day:~~

~~(a) HGP is approved the first day following the end of the sixty days of self-attestation period instead of terminating WCCC;~~

~~(b) The copayment is waived effective the first day of the month following the last day of the sixty days of self-attestation period; and~~

~~(c) The copayment is waived for the remainder of the HGP, even if it is less than four months.~~

~~(d) An overpayment is not established for the sixty days of self-attestations if homelessness is verified and HGP is approved.~~

~~(9)(a) HGP copayments will be determined at initial eligibility determination and be waived for the first four months. A copayment is required for months five through month twelve.~~

~~(b) If the copayment exceeds fifteen dollars, the family will not be eligible for the fifteen dollars copayment during the first two months of paying a required copayment.~~

~~(10) Families will be approved for full-time care during the four months of HGP and the remainder of the eligibility period. Full-time care means:~~

~~(a) Twenty-three full day units when the child needs five or more hours of care per day;~~

~~(b) Thirty half day units when the child needs less than five hours of care per day;~~

~~(c) Thirty half day units during the months of September through June when the child is school-aged; or~~

~~(d) Forty-six half day units during the months of July and August when the child is school-aged.~~

~~(11)(a) Only licensed, certified or DEL-contracted providers shall be authorized to provide child care during the four months of HGP. Payment to the provider will be either the provider rate or state rate, whichever is less.~~

~~(b) In-home/relative providers shall not be authorized to provide child care for families during the HGP, regardless of changes reported.~~

~~(c) Families may choose in-home/relative providers to provide care during months five through twelve, under WAC 170-290-0125, 170-290-0130 and 170-290-0190.~~

~~(d) The four months of HGP are nontransferable; families may not change the four months of HGP, even when care was not provided.~~)) activity as described in WAC 110-15-0040, 110-15-0045, or 110-15-0050;

(ii) Third-party verification of employment; and

(iii) Verification that any outstanding copayment owed by the consumer has been paid or written verification of a payment plan agreed to by the child care provider who is owed the outstanding copayment.

(3) A consumer is eligible for HGP if the consumer:

(a) Is experiencing, and DCYF verifies, homelessness at the time of the consumer's application for benefits;

(b) Has not been approved for HGP within the previous twelve months; and

(c) Except for the requirements described in subsection (1) of this section, meets all eligibility requirements described in this chapter.

(4) Consumers approved by DCYF for HGP are eligible to receive:

(a) A twelve-month certification period;

(b) A copayment waiver; and

(c) An authorization for full-time care as described in WAC 110-15-0190.

(5) Authorizations for HGP eligible consumers may only be authorized for licensed care, certified care, or DCYF contracted provider care.

(6) Consumers authorized care under HGP must provide required verification when reapplying at the end of their certification as described in WAC 110-15-0109.

(7) Consumers approved under HGP are not subject to overpayment unless the consumer obtained benefits by failing to report accurate information that resulted in an error in determining the consumer's eligibility for HGP.

AMENDATORY SECTION (Amending WSR 19-12-058, filed 5/31/19, effective 7/1/19)

WAC 110-15-0200 Daily child care rates—Licensed or certified child care centers and DCYF contracted seasonal day camps. (1) **Base rate.** DCYF pays the lesser of the following to a licensed or certified child care center or DCYF contracted seasonal day camp:

(a) The provider's private pay rate for that child; or

(b) The maximum child care subsidy daily rate for that child as listed in the following table, effective July 1, 2020:

		Infants (One month - 11 mos.)	Toddlers (12 - 29 mos.)	Preschool (30 mos. - 6 yrs not attending kindergarten or school)	School-age (5 - 12 yrs attending kindergarten or school)
Region 1	Full-Day	$((~~35.29~~)) 36.27	$((~~32.44~~)) 34.32	$((~~30.53~~)) 31.64	$((~~29.41~~)) 30.00
	Half-Day	$((~~17.65~~)) 18.14	$((~~16.22~~)) 17.16	$((~~15.27~~)) 15.82	$((~~14.71~~)) 15.00
Spokane County	Full-Day	$((~~45.45~~)) 49.45	$((~~38.77~~)) 42.32	$((~~35.69~~)) 38.32	$((~~27.90~~)) 27.91
	Half-Day	$((~~22.73~~)) 24.73	$((~~19.39~~)) 21.16	$((~~17.85~~)) 19.16	$13.95
Region 2	Full-Day	$((~~39.44~~)) 44.14	$((~~31.67~~)) 34.32	$((~~30.56~~)) 32.82	$((~~23.84~~)) 23.86
	Half-Day	$((~~19.72~~)) 22.07	$((~~15.84~~)) 17.16	$((~~15.28~~)) 16.41	$((~~11.92~~)) 11.93
Region 3	Full-Day	$((~~58.64~~)) 66.86	$((~~49.47~~)) 55.41	$((~~42.59~~)) 48.59	$((~~31.82~~)) 34.77
	Half-Day	$((~~29.32~~)) 33.43	$((~~24.74~~)) 27.70	$((~~21.30~~)) 24.30	$((~~15.91~~)) 17.39
Region 4	Full-Day	$((~~71.76~~)) 84.32	$((~~60.14~~)) 69.09	$((~~55.57~~)) 63.73	$((~~33.41~~)) 39.23
	Half-Day	$((~~35.88~~)) 42.16	$((~~30.07~~)) 34.55	$((~~27.79~~)) 31.86	$((~~16.71~~)) 19.61
Region 5	Full-Day	$((~~48.86~~)) 56.55	$((~~42.51~~)) 46.77	$((~~37.88~~)) 41.91	$((~~26.12~~)) 28.18
	Half-Day	$((~~24.43~~)) 28.27	$((~~21.26~~)) 23.39	$((~~18.94~~)) 20.95	$((~~13.06~~)) 14.09
Region 6	Full-Day	$((~~46.39~~)) 50.36	$((~~40.82~~)) 44.59	$((~~35.56~~)) 40.18	$((~~28.01~~)) 29.41
	Half-Day	$((~~23.20~~)) 25.18	$((~~20.41~~)) 22.30	$((~~17.78~~)) 20.09	$((~~14.01~~)) 14.70

(i) Centers in Clark County are paid Region 3 rates.

(ii) Centers in Benton, Walla Walla, and Whitman counties are paid Region 6 rates.

(2) ((~~The child care center WAC 110-300A-0010 and 110-300A-0050~~)) WAC 110-300-0005 and 110-300-0356 allow((~~s~~)) providers to care for children from ((~~one month~~)) birth up to and including the end of their eligibility period after their thirteenth birthday.

(3) The provider must obtain a child-specific and time-limited exception from ((~~their child care licensor~~)) DCYF to provide care for a child outside the age listed on the center's license.

(4) If ((~~the~~)) a provider ((~~has~~)) is granted an exception to care for a child who ((~~has exceeded the child's thirteenth birthday,~~)) is thirteen years old or older at application or reapplication:

(a) The payment rate is the same as subsection (1) of this section, and the five through twelve year age range column is used for comparison((~~. WAC 110-300A-0010 and 110-300A-0050 are superseded by WAC 110-300-0005 and 110-300-0356, respectively, effective August 1, 2019.~~

~~(3) If the center provider cares for a child who is thirteen or older, the provider must have a child-specific and time-limited exception.~~)); and

(b) The child must meet the special needs requirement ((~~according to~~)) as described in WAC 110-15-0220 ((~~when thirteen or older at application or reapplication~~)).

AMENDATORY SECTION (Amending WSR 20-08-077, filed 3/26/20, effective 4/26/20)

WAC 110-15-0205 Daily child care rates—Licensed or certified family home child care providers. (1) **Base rate.** DCYF pays the lesser of the following to a licensed or certified family home child care provider:

(a) The provider's private pay rate for that child; or

(b) The maximum child care subsidy daily rate for that child as listed in the following table effective July 1, ((~~2019~~)) 2020:

		Infants (Birth - 11 mos.)	Enhanced Toddlers (12 - 17 mos.)	Toddlers (18 - 29 mos.)	Preschool (30 mos. - 6 yrs not attending kindergarten or school)	School-age (5 - 12 yrs attending kindergarten or school)
Region 1	Full-Day	$((~~31.25~~)) 34.32	$((~~31.25~~)) 34.32	$((~~26.79~~)) 29.41	$((~~25.89~~)) 29.41	$((~~22.32~~)) 27.45
	Half-Day	$((~~15.63~~)) 17.16	$((~~15.63~~)) 17.16	$((~~13.39~~)) 14.70	$((~~12.95~~)) 14.70	$((~~11.16~~)) 13.73
Spokane County	Full-Day	$((~~32.59~~)) 39.23	$((~~32.59~~)) 39.23	$((~~27.68~~)) 32.36	$((~~26.79~~)) 31.18	$((~~26.79~~)) 29.41
	Half-Day	$((~~16.29~~)) 19.61	$((~~16.29~~)) 19.61	$((~~13.84~~)) 16.18	$((~~13.39~~)) 15.59	$((~~13.39~~)) 14.70
Region 2	Full-Day	$((~~32.14~~)) 38.23	$((~~32.14~~)) 38.23	$((~~29.46~~)) 34.32	$((~~26.79~~)) 30.86	$((~~25.00~~)) 29.41
	Half-Day	$((~~16.07~~)) 19.11	$((~~16.07~~)) 19.11	$((~~14.73~~)) 17.16	$((~~13.39~~)) 15.43	$((~~12.50~~)) 14.70
Region 3	Full-Day	$((~~42.86~~)) 49.00	$((~~42.86~~)) 49.00	$((~~37.50~~)) 44.14	$((~~36.25~~)) 39.27	$((~~29.38~~)) 34.32
	Half-Day	$((~~21.43~~)) 24.50	$((~~21.43~~)) 24.50	$((~~18.75~~)) 22.07	$((~~18.13~~)) 19.64	$((~~14.69~~)) 17.16
Region 4	Full-Day	$((~~54.37~~)) 58.82	$((~~54.37~~)) 58.82	$((~~48.70~~)) 55.68	$((~~41.07~~)) 49.00	$((~~32.31~~)) 34.32
	Half-Day	$((~~27.19~~)) 29.41	$((~~27.19~~)) 29.41	$((~~24.35~~)) 27.84	$((~~20.54~~)) 24.50	$((~~16.16~~)) 17.16
Region 5	Full-Day	$((~~37.07~~)) 44.14	$((~~37.07~~)) 44.14	$((~~34.90~~)) 39.23	$((~~31.25~~)) 34.32	$((~~26.79~~)) 31.36
	Half-Day	$((~~18.54~~)) 22.07	$((~~18.54~~)) 22.07	$((~~17.45~~)) 19.61	$((~~15.63~~)) 17.16	$((~~13.39~~)) 15.68
Region 6	Full-Day	$((~~33.93~~)) 37.86	$((~~33.93~~)) 37.86	$((~~31.25~~)) 34.32	$((~~28.41~~)) 31.36	$((~~25.89~~)) 28.95
	Half-Day	$((~~16.96~~)) 18.93	$((~~16.96~~)) 18.93	$((~~15.63~~)) 17.16	$((~~14.20~~)) 15.68	$((~~12.95~~)) 14.48

(((~~c) The maximum child care subsidy daily rate for that child as listed in the following table beginning July 1, 2020:~~

		~~Infants (Birth - 11 mos.)~~	~~Enhanced Toddlers (12 - 17 mos.)~~	~~Toddlers (18 - 29 mos.)~~	~~Preschool (30 mos. - 6 yrs not attending kindergarten or school)~~	~~School age (5 - 12 yrs attending kindergarten or school)~~
~~Region 1~~	~~Full-Day~~	~~$33.13~~	~~$33.13~~	~~$28.39~~	~~$27.45~~	~~$23.66~~
	~~Half-Day~~	~~$16.56~~	~~$16.56~~	~~$14.20~~	~~$13.72~~	~~$11.83~~
~~Spokane County~~	~~Full-Day~~	~~$34.54~~	~~$34.54~~	~~$29.34~~	~~$28.39~~	~~$28.39~~
	~~Half-Day~~	~~$17.27~~	~~$17.27~~	~~$14.67~~	~~$14.20~~	~~$14.20~~
~~Region 2~~	~~Full-Day~~	~~$34.07~~	~~$34.07~~	~~$31.23~~	~~$28.39~~	~~$26.50~~
	~~Half-Day~~	~~$17.04~~	~~$17.04~~	~~$15.62~~	~~$14.20~~	~~$13.25~~
~~Region 3~~	~~Full-Day~~	~~$45.43~~	~~$45.43~~	~~$39.75~~	~~$38.43~~	~~$31.14~~
	~~Half-Day~~	~~$22.71~~	~~$22.71~~	~~$19.88~~	~~$19.21~~	~~$15.57~~

		Infants (Birth - 11 mos.)	Enhanced Toddlers (12 - 17 mos.)	Toddlers (18 - 29 mos.)	Preschool (30 mos. - 6 yrs not attending kindergarten or school)	School-age (5 - 12 yrs attending kindergarten or school)
Region 4	Full-Day	$57.63	$57.63	$51.62	$43.54	$34.25
	Half Day	$28.82	$28.82	$25.81	$21.77	$17.13
Region 5	Full-Day	$39.29	$39.29	$37.00	$33.13	$28.39
	Half-Day	$19.65	$19.65	$18.50	$16.56	$14.20
Region 6	Full-Day	$35.96	$35.96	$33.13	$30.11	$27.45
	Half-Day	$17.98	$17.98	$16.56	$15.06	$13.72))

(2) Effective July 1, 2019, family home providers in all regions and for all ages will receive a partial-day rate that is seventy-five percent of the full-day rate when:

(a) The family home provider provides child care services for the child during a morning session and an afternoon session. A morning session begins at any time after 12:00 a.m. and ends before 12:00 p.m. An afternoon session begins at any time after 12:00 p.m. and ends before 12:00 a.m.;

(b) The child is absent from care in order to attend school or preschool; and

(c) The family home provider is not entitled to payment at the full-day rate.

(d) ((~~In no event will~~)) A child care provider ((~~be~~)) is not entitled to two partial-day rates totaling one hundred fifty percent of the daily rate.

(3) A single partial-day monthly unit will be authorized for a school-age child who attends a licensed family home child care and is:

(a) Eligible for a full-time authorization((~~, but is~~)) and in care for less than five hours on a typical school day;

(b) Authorized for care with only one provider; and

(c) Expected to need care before and after school.

Partial-Day Monthly Rates					
	((~~July 1, 2019-June 30,~~)) July-August 2020			((~~July 1, 2020-June 30,~~)) September 2020 - June 2021	
	((~~September-June monthly rate~~	~~July-August monthly rate~~		~~September-June monthly rate~~	~~July-August monthly rate~~))
Region 1	$((~~396.18~~)) 603.90	((~~$491.04~~))		$((~~420.05~~)) 487.24	((~~$520.52~~))
Spokane	$((~~475.48~~)) 647.02	((~~$589.38~~))		$((~~503.88~~)) 522.03	((~~$624.58~~))
Region 2	$((~~443.75~~)) 647.02	((~~$550.00~~))		$((~~470.46~~)) 522.03	((~~$583.00~~))
Region 3	$((~~521.58~~)) 755.04	((~~$646.36~~))		$((~~552.82~~)) 609.18	((~~$685.08~~))
Region 4	$((~~573.63~~)) 755.04	((~~$710.82~~))		$((~~607.98~~)) 609.18	((~~$753.50~~))
Region 5	$((~~475.48~~)) 689.92	((~~$589.38~~))		$((~~503.88~~)) 556.64	((~~$624.58~~))
Region 6	$((~~459.59~~)) 636.90	((~~$569.58~~))		$((~~487.11~~)) 513.86	((~~$603.90~~))

(4) The monthly unit will be prorated for partial months of authorization.

(5) WAC 110-300-0005 and 110-300-0355 allow((~~s~~)) providers to care for children from birth up to and including the end of their eligibility period after their thirteenth birthday.

(6) The provider must obtain a child-specific and time-limited exception from DCYF to provide care for a child outside the age listed on the family home child care license.

(7) If ((~~the family home~~)) a provider ((~~cares~~)) is granted an exception to care for a child who is thirteen years of age or older((~~, the provider must follow WAC 110-300-0300 and 110-300-0355. A child who is thirteen years of age or older at application must meet the special needs requirement according to WAC 110-15-0220. If the provider has an exception to care for a child who has reached the child's thirteenth birthday,~~)) at application or reapplication:

(a) The payment rate is the same as subsection (1) of this section and the five through twelve year age range column is used for comparison; and

(b) The child must meet the special needs requirement as described in WAC 110-15-0220.

((~~(7)~~)) (8) DCYF pays family home child care providers at the licensed home rate regardless of their relation to the children (with the exception listed in subsection ((~~(8)~~)) (9) of this section).

((~~(8)~~)) (9) DCYF cannot pay family home child care providers to provide care for children in their care if the provider is:

(a) The child's biological, adoptive or step-parent;

(b) The child's legal guardian or the guardian's spouse or live-in partner; or

(c) Another adult acting in loco parentis or that adult's spouse or live-in partner.

WSR 20-13-083
WITHDRAWAL OF PROPOSED RULES
SUPERINTENDENT OF PUBLIC INSTRUCTION
(By the Code Reviser's Office)
[Filed June 16, 2020, 12:11 p.m.]

WAC 392-172A-05085, 392-172A-05090, 392-172A-05100, 392-172A-05160, proposed by the superintendent of public instruction in WSR 19-24-077, appearing in issue 19-24 of the Washington State Register, which was distributed on December 18, 2019, is withdrawn by the office of the code reviser under RCW 34.05.335(3), since the proposal was not adopted within the one hundred eighty day period allowed by the statute.

Jennifer C. Meas, Editor
Washington State Register

WSR 20-13-088
PROPOSED RULES
DEPARTMENT OF FISH AND WILDLIFE
[Filed June 16, 2020, 2:55 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 20-09-056 on April 9, 2020.

Title of Rule and Other Identifying Information: The department is considering amendments to WAC 220-412-110 Hunting contests, and 220-413-060 Hunting restrictions.

Hearing Location(s): On July 31-August 1, 2020, at 8 a.m., online webinar.

This meeting will take place by webinar. The public may participate in the meeting. Visit our website at http://wdfw.wa.gov/about/commisssion/meetings or contact the commission office at 360-902-2267 or commission@dfw.wa.gov for instructions on how to join the meeting.

Date of Intended Adoption: August 21, 2020.

Submit Written Comments to: Wildlife Program, P.O. Box 43200, Olympia, WA 98504, email Rules.Coordinator@dfw.wa.gov, fax 360-902-2162, https://www.surveymonkey.com/r/July2020FWC.

Assistance for Persons with Disabilities: Contact Dolores Noyes, phone 360-902-2349, TTY 360-902-2207, email dolores.noyes@dfw.wa.gov, by July 14, 2020.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: There are two proposals related to hunting contests. Presently, an individual wishing to conduct a hunting contest must obtain a permit from the department. The first proposed rule amendment prohibits the department from issuing hunting contest permits for hunting contests involving classified and unclassified wildlife species that do not have bag limits. The purpose of this proposal is to prohibit "spree killing contests" which promote killing large numbers of those species.

Under current law, only the sponsor of an unpermitted contest commits a natural resources infraction. The second proposal makes it illegal for an individual to participate in a hunting contest that is not permitted by the department and specifies that doing so would be punishable as an infraction. The purpose of this proposal is to ensure that individual participants who participate in unpermitted contests are held accountable for participating in unlawful activity.

Reasons Supporting Proposal: Hunting contest permits are issued to nonprofit organizations. Through the hunting contest permit, organizations may hold a hunting contest whereby a monetary prize of up to $2,000 may be offered to the contest participant who harvests the most animals.

The fish and wildlife commission has determined that hunting contests that encourage and reward killing large numbers of native wildlife are not consistent with sound wildlife management principles. The Washington department of fish and wildlife (WDFW) is addressing that concern through this proposed rule amendment. Under this new prohibition, for example, WDFW would no longer issue permits for contests that reward hunters for killing the highest number of coyotes.

Applying accountability measures at the level of the individual participant and clearly stating that there could be a monetary penalty imposed on an individual who is in violation of this rule helps strengthen the enforceability of these rules, thus increasing the likelihood of achieving the objective of the first proposal.

Statutory Authority for Adoption: RCW 77.04.012, 77.04.055, 77.12.047, 77.32.050, and 77.32.525.

Statute Being Implemented: RCW 77.04.012, 77.04.055, 77.12.047, 77.32.050, and 77.32.525.

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

Name of Proponent: WDFD, governmental.

Name of Agency Personnel Responsible for Drafting and Implementation: Eric Gardner, 1111 Washington Street S.E., Olympia, WA 98501, 360-902-2515; and Enforcement: Steve Bear, 1111 Washington Street S.E., Olympia, WA 98501, 360-902-2373.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. A cost-benefit analysis is not required for this rule under RCW 34.05.328.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(4). This chapter does not apply to the adoption of a rule if an agency is able to demonstrate that the proposed rule does not affect small businesses.

Explanation of exemptions: WAC 220-412-110 regulates the activities of hunting contest permit holders, which as specified in WAC 220-412-110, may be held by nonprofit organizations; therefore, this rule does not affect small businesses.

Similarly, WAC 220-413-060 regulates the activities of an individual person who is participating in a hunting contest; therefore, this rule does not affect small businesses.

June 16, 2020
Michele K. Culver
Rules Coordinator

AMENDATORY SECTION (Amending WSR 17-05-112, filed 2/15/17, effective 3/18/17)

WAC 220-412-110 Hunting contests. A person wishing to hold a hunting contest must comply with the following provisions:

(1) Only organizations filed with the state of Washington as a nonprofit corporation may apply for a hunting contest permit.

(2) Hunting contest permit applications shall be submitted to the department 30 days prior to the date for which the contest is proposed.

(3) Applications must include the permit fee required by ((~~RCW 77.32.211~~)) the department. The fee will be returned if the permit is denied.

(4) Contests ((~~are restricted to the species approved on the permit~~)) involving unclassified and classified wildlife species without a bag limit are prohibited and will not be permitted.

(5) Total value of prizes per contest shall not exceed $2000.

(6) Entry fees or requests for donations are prohibited.

(7) It is unlawful to fail to comply with the conditions of a hunting contest permit.

Hunting contests which may adversely affect wildlife resources will be denied.

AMENDATORY SECTION (Amending WSR 17-05-112, filed 2/15/17, effective 3/18/17)

WAC 220-413-060 Hunting restrictions. (1) It is unlawful to hunt wildlife during any modern firearm deer or elk season with any firearm 240 caliber or larger, or containing slugs or buckshot, unless the hunter has a valid license, permits and tags for modern firearm deer or elk seasons are in his or her possession.

(a) This subsection does not apply to people hunting bear, cougar, mountain goat, mountain sheep, or turkey.

(b) A violation of this subsection is punishable under RCW 77.15.410 or 77.15.430, depending on the circumstances of the violation.

(2)(a) It is unlawful to hunt any wildlife at night or wild animals, except rabbits and hares, with dogs (hounds) during the month of October or November during the dates established for eastern and western Washington modern firearm deer or elk general seasons. During the modern firearm deer and elk general seasons the hunting hours are one-half hour before sunrise to one-half hour after sunset. A violation of this subsection is punishable under RCW 77.15.430, Unlawful hunting of wild animals—Penalty.

(b) It is unlawful to use hounds to hunt black bear, cougar (EXCEPT as pursuant to RCW 77.15.245), coyote, and bobcat year-round. A violation of this subsection is punishable under RCW 77.15.410, Unlawful hunting of big game—Penalty, or RCW 77.15.430, depending on the circumstances of the violation.

(3) It is unlawful to participate in a hunting contest for which no permit has been issued by the department. A violation of this subsection is punishable as an infraction under RCW 77.15.160 (6)(b).

WSR 20-13-089
PROPOSED RULES
DEPARTMENT OF ECOLOGY

[Filed June 16, 2020, 3:31 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 19-16-060.

Title of Rule and Other Identifying Information: Ecology is proposing a new permanent rule for chapter 173-443 WAC, Hydrofluorocarbons (HFCs), to reduce greenhouse gases in Washington by transitioning to the use of less damaging HFCs or suitable substitutes.

For more information on this rule making visit https://ecology.wa.gov/Regulations-Permits/Laws-rules-rulemaking/Rulemaking/WAC173-443.

Hearing Location(s): On July 21, 2020, at 9:30 a.m. PDT, webinar only.

Presentation, question and answer session followed by the hearing.

We are holding this hearing via webinar. This is an online meeting that you can attend from any computer using internet access.

Join online and see instructions https://watech.webex.com/watech/onstage/g.php?MTID=e2dea34b45e060fd36c5f76c6ab8aa601.

For audio call U.S. Toll number 1-855-929-3239 and enter access code 284 632 939. Or to receive a free call back, provide your phone number when you join the event.

Date of Intended Adoption: November 17, 2020.

Submit Written Comments to: Linda Kildahl, send U.S. mail at Department of Ecology, Air Quality Program, P.O. Box 47600, Olympia, WA 98504-7600 (U.S. mail); or send parcel delivery services to Department of Ecology, Air Quality Program, 300 Desmond Drive S.E., Lacey, WA 98503, submit comments by mail, online, or at the hearing(s), online http://aq.ecology.commentinput.com/?id=g7B9h, by July 28, 2020.

Assistance for Persons with Disabilities: Contact ecology ADA coordinator, phone 360-407-6831, for Washington relay service or TTY call 711 or 877-833-6341, email ecyADAcoordinator@ecy.wa.gov, visit https://ecology.wa.gov/accessibility for more information, by July 17, 2020.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposed rule prohibits the use of HFCs and other substitutes in various products and equipment in the air conditioning and refrigeration, aerosol propellant, and foam end-use categories. This will occur in a phased approach, similar to rules adopted under EPA's Significant New Alternatives Policy (SNAP) program and HFC rules adopted or proposed for adoption by other states around the country.

The proposed rule defines requirements for manufacturers, importers, and distributors of covered products and equipment to:

- Notify ecology about the use of HFCs and other prohibited substitutes.
- Disclose HFCs and other substitutes used in an on-product label or other designated format.

Ecology modified the prohibition date for the new and existing vending machine end-use category from January 1, 2020, to January 1, 2022.

Reasons Supporting Proposal: The Washington legislature specifically directed ecology to engage in rule making to implement a program for transitioning away from HFCs. The proposed rule implements the prohibitions in the same end-use categories as in SNAP Rules 20 and 21 that were in effect on January 3, 2017, but with a new timeline for the prohibitions to take effect.

Consistent with RCW 70.235.080 (3)(a), ecology determined that the modified effective date for new and existing vending machines from January 1, 2020, to January 1, 2022, reduces the overall risk to human health or the environment and reflects the earliest date that a lower risk substitute is currently or potentially available.

Statutory Authority for Adoption: Chapter 70.235 RCW, Limiting greenhouse gas emissions.

Statute Being Implemented: Chapter 70.235 RCW.

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

Agency Comments or Recommendations, if any, as to Statutory Language, Implementation, Enforcement, and Fiscal Matters: To meet statutory deadlines in the law, ecology adopted three emergency rules while working on the permanent rule. Ecology plans to adopt two more emergency rules before the permanent rule goes into effect by the end of 2020.

The emergency rules were adopted as follows:

The first emergency rule on July 30, 2019 (WSR 19-16-059).

The second emergency rule on November 21, 2019 (WSR 19-24-005).

The third emergency rule on March 16, 2020 (WSR 20-07-076[]).

Name of Proponent: Department of ecology, governmental.

Name of Agency Personnel Responsible for Drafting: Linda Kildahl, 300 Desmond Drive, Lacey, WA 98503, 360-407-7655; Implementation and Enforcement: Abbey Brown, 300 Desmond Drive, Lacey, WA 98503, 360-407-6826.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Linda Kildahl, 300 Desmond Drive, Lacey, WA 98503, phone 360-407-7655, for Washington relay service or TTY call 711 or 877-833-6341, email linda.kildahl@ecy.wa.gov.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.020(1), 19.85.030(1), 19.85.025(4).

Explanation of exemptions: The Regulatory Fairness Act (RFA; RCW 19.85.070) requires ecology to perform a set of analyses and make certain determinations regarding proposed rules, if they impose more than minor compliance costs on businesses in an industry.

We analyzed the compliance costs of the proposed rule, and whom they fall on, in chapter 3 of this document. We determined that no businesses in Washington state would incur compliance costs under the proposed rule. Based on the available list of manufacturers (who were all required to report to ecology by December 31, 2019, under the baseline), we expect all affected manufacturers to be businesses outside of Washington state (in other states or other countries, while their products are sold in Washington).

Based on this analysis, ecology is exempt from performing additional analyses under the RFA, specifically (bold added for emphasis):

- RCW 19.85.020(1), which defines industry: "**"Industry" means all of the businesses in this state** in any one four-digit standard industrial classification as published by the United States department of commerce, or the North American industry classification system as published by the executive office of the president and the office of management and budget."
- RCW 19.85.030 (1)(a), which states: "In the adoption of a rule under chapter 34.05 RCW, an agency shall prepare a small business economic impact statement: (i) If the proposed rule will impose more than minor costs on **businesses in an industry;** or (ii) if requested to do so by a majority vote of the joint administrative rules review committee within forty-five days of receiving the notice of proposed rulemaking under RCW 34.05.320."
- RCW 19.85.025(4), which states: "This chapter does not apply to the adoption of a rule if an agency is able to demonstrate that the proposed rule does not affect **small businesses.**"

June 16, 2020
Heather Bartlett
Deputy Director

Chapter 173-443 WAC

HYDROFLUOROCARBONS (HFCs)

NEW SECTION

WAC 173-443-010 Policy and purpose. (1) Ecology's policy under chapters 70.94 and 43.21A RCW is to provide for the systematic control of air pollution from air contaminant sources. Ecology's policy under chapter 70.235 RCW is to reduce the emissions of greenhouse gases.

(2) This chapter establishes requirements for the transition to less damaging HFCs or suitable substitutes in the air conditioning and refrigeration, aerosol propellant, and foam end-use categories in Washington in a manner similar to rules adopted under EPA's Significant New Alternative Policy (SNAP) program and HFC rules adopted or proposed for adoption by other states around the country (RCW 70.235.-080).

NEW SECTION

WAC 173-443-020 Applicability. (1) The requirements of this chapter apply to any person who offers for sale, leases, rents, installs, or otherwise causes to enter into Washington commerce any product or equipment that contains,

uses, or will use HFCs or other substitutes for an end-use listed in WAC 173-443-040.

(2) Labeling requirements.

(a) The labeling requirements in WAC 173-443-070 apply to manufacturers of products or equipment that contains, uses, or will use HFCs as of July 28, 2019, or to manufacturers that introduce such products or equipment into Washington commerce after that date.

(b) A manufacturer may apply the applicability determination in (a) of this subsection to separate divisions or similar segments of its business based on the end-use that products associated with each division or similar segmentation are intended to serve.

NEW SECTION

WAC 173-443-030 Definitions and acronyms. The definitions in this section apply throughout this chapter unless the text clearly indicates otherwise.

"Aerosol propellant" means a liquid or compressed gas that is used in whole or in part, such as a cosolvent, to expel a liquid or other material from the same self-pressurized container or from a separate container.

"Bunstock" or "bun stock" means a large solid box-like structure formed during the production of polyurethane, polyisocyanurate, phenolic, or polystyrene insulation.

"C" means Centigrade.

"Centrifugal chiller" means air conditioning equipment that utilizes a centrifugal compressor in a vapor-compression refrigeration cycle typically used for commercial comfort air conditioning. Under this definition, a centrifugal chiller is a chiller intended for comfort cooling and does not include chillers for industrial process cooling and refrigeration.

"Code" means a collection of letters, numbers, graphics, or symbols that translates into a form that conveys the information provided by a dedicated or existing product label, or that can convey a user or reader to that information through electronic means (such as a QR code).

"Cold storage warehouse" means a cooled facility designed to store meat, produce, dairy products, and other products that are delivered to other locations for sale to the ultimate consumer.

"Commercial refrigeration equipment" means equipment designed to store and display chilled or frozen goods for commercial sale including, but not limited to, stand-alone units, refrigerated food processing and dispensing equipment, remote condensing units, supermarket systems, and vending machines.

"Component" means a part of a refrigeration system including, but not limited to, condensing units, compressors, evaporators, and receivers; and all of its connections and subassemblies, without which the refrigeration system will not properly function or will be subject to failures.

"Dedicated label" means a label adhered or attached to a product, or otherwise included with the product, that is designed to convey required information to the end-user of that product on the inclusion or use of substitutes associated with that product.

"EPA" means the U.S. Environmental Protection Agency.

"Ecology" means the department of ecology.

"End-use" means processes or classes of specific applications within industry sectors including, but not limited to, those listed in WAC 173-443-040.

"Equipment" means a collection of components assembled or manufactured to function together that contains at least one product, or that is in and of itself a product.

"Existing product label" means a label adhered or attached to a product, such as a nameplate or sticker, or to the box or packaging enclosing the product that discloses the substitute contained, used, or to be used in the product.

"F" means Fahrenheit.

"Flexible polyurethane" means a nonrigid synthetic foam containing polymers of urethane radicals including, but not limited to, that used in furniture, bedding, chair cushions, and shoe soles.

"Foam" means a product with a cellular structure formed via a foaming process in a variety of materials that undergo hardening via a chemical reaction or phase transition.

"Foam blowing agent" means a product or substance used to produce the product with a cellular structure formed via a foaming process in a variety of materials that undergo hardening or phase transition.

"Foam system" means a multipart liquid material that expands when mixed to form a solid or flexible substance in which thin films of material separate pockets of gas.

"HFC" means hydrofluorocarbon as the term is defined in RCW 70.235.010.

"Household refrigerators and freezers" means refrigerators, refrigerator-freezers, freezers, and miscellaneous household refrigeration appliances intended for residential use. "Household refrigerators and freezers" does not include "household refrigerators and freezers - Compact," or "household refrigerators and freezers - Built-in."

"Household refrigerators and freezers - Built-in" means any refrigerator, refrigerator-freezer or freezer intended for residential use with 7.75 cubic feet or greater total volume and twenty-four inches or less depth not including doors, handles, and custom front panels; with sides which are not finished and not designed to be visible after installation; and that is designed, intended, and marketed exclusively to be: Installed totally encased by cabinetry or panels that are attached during installation; securely fastened to adjacent cabinetry, walls or floor; and equipped with an integral factory-finished face or accept a custom front panel.

"Household refrigerators and freezers - Compact" means any refrigerator, refrigerator-freezer or freezer intended for residential use with a total refrigerated volume of less than 7.75 cubic feet (220 liters).

"Integral skin polyurethane" means a synthetic self-skinning foam containing polymers of urethane radicals including, but not limited to, that used in shoe soles and car steering wheels.

"MDI" means metered dose inhaler or medical dose inhaler.

"Manufacturer" means any person, firm, association, partnership, corporation, governmental entity, organization, or joint venture that produces any product that contains or uses HFCs or is an importer or domestic distributor of such a product (RCW 70.235.010).

"New" means:

(a) Products or equipment that are manufactured after the effective date of this chapter;

(b) Products or equipment first installed for an intended purpose with new or used components;

(c) Products or equipment expanded by the addition of components to increase system capacity after the effective date of this chapter; or

(d) Products or equipment replaced or cumulatively replaced such that the cumulative capital cost after the effective date of this chapter of replacement exceeds fifty percent of the capital cost of replacing the whole system.

"Nonretail foam products" means products consisting entirely of foam created solely to be an input for another product or manufacturing purpose resulting in another type of product.

"Online disclosure" means disclosing the substitute contained, used, or to be used in products or equipment by ensuring that the information is available on an internet website that is accessible to the public free of charge.

"Owner's manual" means a paper or online instructional book that is available for an end-use product, that provides basic information about the product.

"PSI" means pounds per square inch.

"Person" means an individual, partnership, franchise holder, association, corporation, a state, a city, a county, or any subdivision or instrumentality of the state (RCW 70.235.010).

"Phenolic insulation board and bunstock" means phenolic insulation including, but not limited to, that used for roofing and wall insulation.

"Polyolefin" means foam sheets and tubes made of polyolefin, a macromolecule formed by the polymerization of olefin monomer units.

"Polystyrene extruded boardstock and Billet (XPS)" means a foam formed from polymers of styrene and produced on extruding machines in the form of continuous foam slabs which can be cut and shaped into panels used for roofing, walls, flooring, and pipes.

"Polystyrene extruded sheet" means polystyrene foam including that used for packaging and buoyancy or floatation. It is also made into food-service items, including hinged polystyrene containers (for "take-out" from restaurants); food trays (meat and poultry) plates, bowls, and retail egg containers.

"Polyurethane" means a polymer formed principally by the reaction of an isocyanate and a polyol.

"Positive displacement chiller" means vapor compression cycle chillers that use positive displacement compressors, typically used for commercial comfort air conditioning. Positive displacement chiller in this definition is a chiller intended for comfort cooling and does not include cooling for industrial process cooling and refrigeration.

"Product" means an article manufactured or refined for sale that contains or uses a substitute.

"Refrigerant" or "refrigerant gas" means any substance, including blends and mixtures, which is used for heat transfer purposes.

"Refrigerated food processing and dispensing equipment" means retail food refrigeration equipment that is designed to process food and beverages dispensed via a nozzle that are intended for immediate or near-immediate consumption including, but not limited to, chilled and frozen beverages, ice cream, and whipped cream. This end-use excludes water coolers, or units designed solely to cool and dispense water.

"Refrigeration equipment" means any stationary device that is designed to contain and use refrigerant gas including, but not limited to, retail or commercial refrigeration equipment, household refrigeration equipment, and cold storage warehouses.

"Remote condensing units" means retail refrigeration equipment or units that have a central condensing portion and may consist of one or more compressors, condensers, and receivers assembled into a single unit, which may be located external to the sales area. The condensing portion (and often other parts of the system) is located outside the space or area cooled by the evaporator. Remote condensing units are commonly installed in convenience stores, specialty shops (e.g., bakeries, butcher shops), supermarkets, restaurants, and other locations where food is stored, served, or sold.

"Retail foam products" means products consisting entirely of foam that are created for the purpose of selling or otherwise providing that product in a finished state that does not involve any additional manufacturing or refinement.

"Retrofit" means to convert an appliance from one refrigerant to another refrigerant. Retrofitting includes the conversion of the appliance to achieve system compatibility with the new refrigerant and may include, but is not limited to, changes in lubricants, gaskets, filters, driers, valves, o-rings, or appliance components (RCW 70.235.010).

"Rigid polyurethane and polyisocyanurate laminated boardstock" means laminated board insulation made with polyurethane or polyisocyanurate foam, including that used for roofing and walls.

"Rigid polyurethane appliance foam" means polyurethane insulation foam in domestic appliances.

"Rigid polyurethane commercial refrigeration and sandwich panels" means polyurethane insulation for use in walls and doors, including that used for commercial refrigeration equipment, and used in doors, including garage doors.

"Rigid polyurethane high-pressure two-component spray foam" means a foam product that is pressurized 800-1600 psi during manufacture; sold in pressurized containers as two parts (i.e., A-side and B-side); and is blown and applied in situ using high-pressure pumps to propel the foam components, and may use liquid blowing agents without an additional propellant.

"Rigid polyurethane low-pressure two-component spray foam" means a foam product that is pressurized to less than 250 psi during manufacture; sold in pressurized containers as two parts (i.e., A-side and B-side); and are typically applied in situ relying upon a gaseous foam blowing agent that also serves as a propellant so pumps typically are not needed.

"Rigid polyurethane marine flotation foam" means buoyancy or flotation foam used in boat and ship manufacturing for both structural and flotation purposes.

"Rigid polyurethane one-component foam sealants" means a foam packaged in aerosol cans that is applied in situ

using a gaseous foam blowing agent that is also the propellant for the aerosol formulation.

"Rigid polyurethane slabstock and other" means a rigid closed-cell foam containing polymers of urethane radicals formed into slabstock insulation for panels and pipes.

"Stand-alone low-temperature unit" means a stand-alone unit that maintains food or beverages at temperatures at or below 32°F (0°C).

"Stand-alone medium-temperature unit" means a stand-alone unit that maintains food or beverages at temperatures above 32°F (0°C).

"Stand-alone unit" means retail refrigerators, freezers, and reach-in coolers (either open or with doors) where all refrigeration components are integrated and, for the smallest types, the refrigeration circuit is entirely brazed or welded. These systems are fully charged with refrigerant at the factory and typically require only an electricity supply to begin operation.

"Substitute" means a chemical, product substitute, or alternative manufacturing process, whether existing or new, that is used to perform a function previously performed by a class I substance or class II substance and any substitute subsequently adopted to perform that function including, but not limited to, hydrofluorocarbons. "Substitute" does not include 2-BPT or any compound as applied to its use in aerospace fire extinguishing systems (RCW 70.235.010).

"Supermarket systems" means multiplex or centralized retail food refrigeration equipment systems designed to cool or refrigerate, which operate with racks of compressors installed in a machinery room and which includes both direct and indirect systems.

"Symbol" means a graphical or hybrid word-graphical symbol for the purposes of conveying the types of substitutes used in the product or equipment and signaling that further information on the use of substitutes is available through online disclosure.

"Unit" means a collection of like products bundled together for purposes of commerce.

"Unit label" means a label adhered or attached, or capable of being adhered or attached, to a collection of like products bundled together for purposes of commerce.

"Vending machine" means a self-contained unit that dispenses goods that must be kept cold or frozen.

NEW SECTION

WAC 173-443-040 List of prohibited substitutes. (1) The tables in this section list substitutes prohibited in specific end-uses and the effective date of prohibition, unless an exemption is provided for in WAC 173-443-050.

(2) Prohibitions for the aerosol propellants end-use category.

End-Use Category: Aerosol Propellants		
End-Use	**Prohibited Substitutes**	**Effective Date**
Aerosol propellants	HFC-125, HFC-134a, HFC-227ea and blends of HFC-227ea and HFC-134a	January 1, 2020

(3) Prohibitions for the air conditioning end-use category.

End-Use Category: Air Conditioning		
End-Use	**Prohibited Substitutes**	**Effective Date**
Centrifugal chillers (new)	FOR12A, FOR12B, HFC-134a, HFC-227ea, HFC-236fa, HFC-245fa, R-125/134a/600a (28.1/70/1.9), R-125/290/134a/600a (55.0/1.0/42.5/1.5), R-404A, R-407C, R-410A, R-410B, R-417A, R-421A, R-422B, R-422C, R-422D, R-423A, R-424A, R-434A, R-438A, R-507A, RS-44 (2003 composition), THR-03	January 1, 2024
Positive displacement chillers (new)	FOR12A, FOR12B, HFC-134a, HFC-227ea, KDD6, R-125/134a/600a (28.1/70/1.9), R-125/290/134a/600a (55.0/1.0/42.5/1.5), R-404A, R-407C, R-410A, R-410B, R-417A, R-421A, R-422B, R-422C, R-422D, R-424A, R-434A, R-437A, R-438A, R-507A, RS-44 (2003 composition), SP34E, THR-03	January 1, 2024

(4) Prohibitions for the refrigeration end-use category.

End-Use Category: Refrigeration		
End-Use	**Prohibited Substitutes**	**Effective Date**
Cold storage warehouses (new)	HFC-227ea, R-125/290/134a/600a (55.0/1.0/42.5/1.5), R-404A, R-407A, R-407B, R-410A, R-410B, R-417A, R-421A, R-421B, R-422A, R-422B, R-422C, R-422D, R-423A, R-424A, R-428A, R-434A, R-438A, R-507A, RS-44 (2003 composition)	January 1, 2023
Household refrigerators and freezers (new)	FOR12A, FOR12B, HFC-134a, KDD6, R-125/290/134a/600a (55.0/1.0/42.5/1.5), R-404A, R-407C, R-407F, R-410A, R-410B, R-417A, R-421A, R-421B, R-422A, R-422B, R-422C, R-422D, R-424A, R-426A, R-428A, R-434A, R-437A, R-438A, R-507A, RS-24 (2002 formulation), RS-44 (2003 formulation), SP34E, THR-03	January 1, 2022
Household refrigerators and freezers - Compact (new)	FOR12A, FOR12B, HFC-134a, KDD6, R-125/290/134a/600a (55.0/1.0/42.5/1.5), R-404A, R-407C, R-407F, R-410A, R-410B, R-417A, R-421A, R-421B, R-422A, R-422B, R-422C, R-422D, R-424A, R-426A, R-428A, R-434A, R-437A, R-438A, R-507A, RS-24 (2002 formulation), RS-44 (2003 formulation), SP34E, THR-03	January 1, 2021
Household refrigerators and freezers - Built-in appliances (new)	FOR12A, FOR12B, HFC-134a, KDD6, R-125/290/134a/600a (55.0/1.0/42.5/1.5), R-404A, R-407C, R-407F, R-410A, R-410B, R-417A, R-421A, R-421B, R-422A, R-422B, R-422C, R-422D, R-424A, R-426A, R-428A, R-434A, R-437A, R-438A, R-507A, RS-24 (2002 formulation), RS-44 (2003 formulation), SP34E, THR-03	January 1, 2023
Supermarket systems (retrofit)	R-404A, R-407B, R-421B, R-422A, R-422C, R-422D, R-428A, R-434A, R-507A	January 1, 2020
Supermarket systems (new)	HFC-227ea, R-404A, R-407B, R-421B, R-422A, R-422C, R-422D, R-428A, R-434A, R-507A	January 1, 2020
Remote condensing units (retrofit)	R-404A, R-407B, R-421B, R-422A, R-422C, R-422D, R-428A, R-434A, R-507A	January 1, 2020
Remote condensing units (new)	HFC-227ea, R-404A, R-407B, R-421B, R-422A, R-422C, R-422D, R-428A, R-434A, R-507A	January 1, 2020
Stand-alone units (retrofit)	R-404A, R-507A	January 1, 2020
Stand-alone medium-temperature units (new)	FOR12A, FOR12B, HFC-134a, HFC-227ea, KDD6, R-125/290/134a/600a (55.0/1.0/42.5/1.5), R-404A, R-407A, R-407B, R-407C, R-407F, R-410A, R-410B, R-417A, R-421A, R-421B, R-422A, R-422B, R-422C, R-422D, R-424A, R-426A, R-428A, R-434A, R-437A, R-438A, R-507A, RS-24 (2002 formulation), RS-44 (2003 formulation), SP34E, THR-03	January 1, 2020
Stand-alone low-temperature units (new)	HFC-227ea, KDD6, R-125/290/134a/600a (55.0/1.0/42.5/1.5), R-404A, R-407A, R-407B, R-407C, R-407F, R-410A, R-410B, R-417A, R-421A, R-421B, R-422A, R-422B, R-422C, R-422D, R-424A, R-428A, R-434A, R-437A, R-438A, R-507A, RS-44 (2003 formulation)	January 1, 2020
Refrigerated food processing and dispensing equipment (new)	HFC-227ea, KDD6, R-125/290/134a/600a (55.0/1.0/42.5/1.5), R-404A, R-407A, R-407B, R-407C, R-407F, R-410A, R-410B, R-417A, R-421A, R-421B, R-422A, R-422B, R-422C, R-422D, R-424A, R-428A, R-434A, R-437A, R-438A, R-507A, RS-44 (2003 formulation)	January 1, 2021

End-Use Category: Refrigeration		
End-Use	**Prohibited Substitutes**	**Effective Date**
Vending machines (retrofit)	R-404A, R-507A	January 1, 2022
Vending machines (new)	FOR12A, FOR12B, HFC-134a, KDD6, R-125/290/134a/600a (55.0/1.0/42.5/1.5), R-404A, R-407C, R-410A, R-410B, R-417A, R-421A, R-422B, R-422C, R-422D, R-426A, R-437A, R-438A, R-507A, RS-24 (2002 formulation), SP34E	January 1, 2022

(5) Prohibitions for the foams end-use category.

End-Use Category: Foams		
End-Use	**Prohibited Substitutes**	**Effective Date**
Rigid polyurethane and polyisocyanurate laminated boardstock	HFC-134a, HFC-245fa, HFC-365mfc, and blends thereof	January 1, 2020
Flexible polyurethane	HFC-134a, HFC-245fa, HFC-365mfc, and blends thereof	January 1, 2020
Integral skin polyurethane	HFC-134a, HFC-245fa, HFC-365mfc, and blends thereof; Formacel TI, Formacel Z-6	January 1, 2020
Polystyrene extruded sheet	HFC-134a, HFC-245fa, HFC-365mfc, and blends thereof; Formacel TI, Formacel Z-6	January 1, 2020
Phenolic insulation board and bunstock	HFC-143a, HFC-134a, HFC-245fa, HFC-365mfc, and blends thereof	January 1, 2020
Rigid polyurethane slabstock and other	HFC-134a, HFC-245fa, HFC-365mfc, and blends thereof; Formacel TI, Formacel Z-6	January 1, 2020
Rigid polyurethane appliance foam	HFC-134a, HFC-245fa, HFC-365mfc, and blends thereof; Formacel TI, Formacel Z-6	January 1, 2020
Rigid polyurethane commercial refrigeration and sandwich panels	HFC-134a, HFC-245fa, HFC-365mfc, and blends thereof; Formacel TI, Formacel Z-6	January 1, 2020
Polyolefin	HFC-134a, HFC-245fa, HFC-365mfc, and blends thereof; Formacel TI, Formacel Z-6	January 1, 2020
Rigid polyurethane marine flotation foam	HFC-134a, HFC-245fa, HFC-365mfc, and blends thereof; Formacel TI, Formacel Z-6	January 1, 2020
Polystyrene extruded boardstock and billet (XPS)	HFC-134a, HFC-245fa, HFC-365mfc, and blends thereof; Formacel TI, Formacel B, Formacel Z-6	January 1, 2021
Rigid polyurethane high-pressure two-component spray foam	HFC-134a, HFC-245fa, and blends thereof; blends of HFC-365mfc with at least 4 percent HFC-245fa, and commercial blends of HFC-365mfc with 7 to 13 percent HFC-227ea and the remainder HFC-365mfc; Formacel TI	January 1, 2020
Rigid polyurethane low-pressure two-component spray foam	HFC-134a, HFC-245fa, and blends thereof; blends of HFC-365mfc with at least 4 percent HFC-245fa, and commercial blends of HFC-365mfc with 7 to 13 percent HFC-227ea and the remainder HFC-365mfc; Formacel TI	January 1, 2021
Rigid polyurethane one-component foam sealants	HFC-134a, HFC-245fa, and blends thereof; blends of HFC-365mfc with at least 4 percent HFC-245fa, and commercial blends of HFC-365mfc with 7 to 13 percent HFC-227ea and the remainder HFC-365mfc; Formacel TI	January 1, 2020

NEW SECTION

WAC 173-443-050 Exemptions. The following table lists exemptions to the prohibitions in WAC 173-443-040.

End-Use Category	Prohibited Substitutes	Acceptable Uses
Aerosol propellants	HFC-134a	Cleaning products for removal of grease, flux and other soils from electrical equipment; refrigerant flushes; products for sensitivity testing of smoke detectors; lubricants and freeze sprays for electrical equipment or electronics; sprays for aircraft maintenance; sprays containing corrosion preventive compounds used in the maintenance of aircraft, electrical equipment or electronics, or military equipment; pesticides for use near electrical wires, in aircraft, in total release insecticide foggers, or in certified organic use pesticides for which EPA has specifically disallowed all other lower-GWP propellants; mold release agents and mold cleaners; lubricants and cleaners for spinnerettes for synthetic fabrics; duster sprays specifically for removal of dust from photographic negatives, semiconductor chips, specimens under electron microscopes, and energized electrical equipment; adhesives and sealants in large canisters; document preservation sprays; FDA-approved MDIs for medical purposes; wound care sprays; topical coolant sprays for pain relief; products for removing bandage adhesives from skin; bear spray; and pepper spray.
Aerosol propellants	HFC-227ea and blends of HFC-227ea and HFC-134a	FDA-approved MDIs for medical purposes.
Air conditioning	HFC-134a	Military marine vessels where reasonable efforts have been made to ascertain that other alternatives are not technically feasible due to performance or safety requirements.
Air conditioning	HFC-134a and R-404A	Human-rated spacecraft and related support equipment where reasonable efforts have been made to ascertain that other alternatives are not technically feasible due to performance or safety requirements.
Foams - Except rigid polyurethane spray foam	All substitutes	Military applications where reasonable efforts have been made to ascertain that other alternatives are not technically feasible due to performance or safety requirements until January 1, 2022.
Foams - Except rigid polyurethane spray foam	All substitutes	Space- and aeronautics-related applications where reasonable efforts have been made to ascertain that other alternatives are not technically feasible due to performance or safety requirements until January 1, 2025.
Rigid polyurethane two-component spray foam	All substitutes	Military or space- and aeronautics-related applications where reasonable efforts have been made to ascertain that other alternatives are not technically feasible due to performance or safety requirements until January 1, 2025.

NEW SECTION

WAC 173-443-060 Prohibitions. (1) No person may offer for sale, lease, rent, install, or otherwise cause to enter into Washington commerce any product or equipment that contains, uses, or will use HFCs or other substitutes prohibited for an end-use in WAC 173-443-040 unless an exemption is provided for in WAC 173-443-050.

(2) Products and equipment manufactured prior to the applicable effective date of a prohibition in WAC 173-443-040 may be sold, leased, rented, or otherwise introduced into Washington commerce after the date of prohibition.

(a) For products and equipment imported from outside the United States, the date of import may be considered the date of manufacture.

(b) For refrigeration equipment and chillers, the date the manufacturer affixed an equipment label indicating the equipment's date of manufacture is the date of manufacture.

(c) Spray foam systems manufactured (blended) before an applicable prohibition date and not yet applied on site may be used after the prohibition date.

(3) Except where an existing system is retrofit, nothing in this chapter requires a person that acquired a product or equipment containing or using a prohibited substitute prior to the effective date of a prohibition in WAC 173-443-040 to cease use of that product or equipment.

NEW SECTION

WAC 173-443-070 Product labeling and disclosure requirements. (1) Except for products and equipment that

use prohibited substitutes for an acceptable use listed in WAC 173-443-050, a manufacturer must disclose the substitutes contained, used, or to be used in its products or equipment applicable to the end-uses listed in WAC 173-443-040.

(2) This disclosure must occur no later than one year following an applicable prohibition date, or no later than one year following the effective date of this chapter.

(3) A manufacturer of aerosol propellant products must disclose the substitutes through one of following methods:

(a) For aerosol products regulated by the U.S. Food and Drug Administration excluding prescription drug products, the U.S. Consumer Product Safety Commission, or products that are not covered by (b) of this subsection:

(i) New dedicated label;

(ii) Existing product label;

(iii) On-packaging label;

(iv) On-product symbol or code; and online disclosure; or

(v) On-packaging symbol or code; and online disclosure.

(b) For aerosol products regulated by EPA under the Federal Insecticide Fungicide and Rodenticide Act, aerosol products regulated by the Occupational Safety and Health Administration, or aerosol prescription drug products regulated by the U.S. Food and Drug Administration:

(i) Any option in (a)(i) through (v) of this subsection; or

(ii) A product document, such as a Safety Data Sheet (SDS), that complies with the 29 C.F.R. 1910.1200; and online disclosure if the SDS is not posted online.

(4) A manufacturer of refrigeration products and equipment (including refrigeration products and equipment that contain foam) must disclose the substitutes through one of following methods:

(a) For the refrigerant used in household refrigerators and freezers, household refrigerators and freezers - Compact, and household refrigerators and freezers - Built-in:

(i) New dedicated label;

(ii) Underwriters Laboratories or equivalent safety label; or

(iii) On-product or on-equipment symbol or code; and online disclosure.

(b) For the foam blown in or installed by the manufacturer of household refrigerators and freezers, household refrigerators and freezers - Compact, and household refrigerators and freezers - Built-in:

(i) New dedicated label;

(ii) Underwriters Laboratories or equivalent safety label;

(iii) Owner's manual; or

(iv) On-product or on-equipment symbol or code; and online disclosure.

(c) For the refrigerant used in commercial refrigeration equipment:

(i) New dedicated label;

(ii) Existing product label;

(iii) Underwriters Laboratories or equivalent safety label; or

(iv) On-product or on-equipment symbol or code; and online disclosure.

(d) For the foam blown in or installed by the manufacturer of commercial refrigeration equipment:

(i) New dedicated label;

(ii) Existing product label;

(iii) Underwriters Laboratories or equivalent safety label;

(iv) Owner's manual; or

(v) On-product or on-equipment symbol or code; and online disclosure.

(5) A manufacturer of centrifugal or positive displacement chillers must disclose the substitutes through one of following methods:

(a) For the refrigerant used in centrifugal and positive displacement chillers:

(i) New dedicated label;

(ii) Existing product label;

(iii) Underwriters Laboratories or equivalent safety label; or

(iv) On-product or on-equipment symbol or code; and online disclosure.

(b) For the foam blown in or installed by the manufacturer of centrifugal and positive displacement chillers:

(i) New dedicated label;

(ii) Existing product label;

(iii) Underwriters Laboratories or equivalent safety label;

(iv) Owner's manual; or

(v) On-product or on-equipment symbol or code; and online disclosure.

(6) A manufacturer of foam products must disclose the substitutes through one of following methods:

(a) For nonretail foam products:

(i) Unit label; or

(ii) One of the following methods for each individual product within a unit:

(A) New dedicated label;

(B) Existing product label;

(C) A label required by another jurisdiction with sufficient HFC disclosure requirements; and online disclosure; or

(D) On-product symbol or code; and online disclosure.

(b) For retail foam products:

(i) New dedicated label;

(ii) Existing product label;

(iii) On-packaging label;

(iv) A label required by another jurisdiction with sufficient HFC disclosure requirements; and online disclosure;

(v) On-product symbol or code; and online disclosure; or

(vi) On-packaging symbol or code; and online disclosure.

(c) For the foam blowing agent used in spray foam:

(i) New dedicated label on the canister or cylinders;

(ii) Existing product label on the canister or cylinders;

(iii) On-packaging label; or

(iv) On-packaging symbol or code; and online disclosure.

(7) Ecology must approve in advance the use of a symbol or code to comply with this section.

(8) Ecology must approve in advance the use of another jurisdiction's HFC disclosure label.

(9) The requirements of this section do not apply to aircraft and aircraft components subject to certification requirements of the Federal Aviation Administration.

NEW SECTION

WAC 173-443-080 Manufacturer notification. (1) A manufacturer of a product or equipment that contains, uses, or will use HFCs or other substitutes prohibited in WAC 173-443-040 or a representative on behalf of the manufacturer, must report to ecology consistent with WAC 173-443-090 and 173-443-100.

(2) It is only necessary for one person or entity to report with respect to a particular product or equipment.

(3) In the event of a failure by at least one person to provide a complete, accurate, and timely report for a product or equipment within a specific end-use, ecology will require information from the manufacturer associated with the product or equipment in the following order of precedence:

(a) The person or entity that manufactured, produced, or assembled the product or equipment, unless it has no presence in the United States.

(b) The person or entity that marketed the product or equipment under its name or trademark, unless it has no presence in the United States.

(c) The first person or entity, whether an importer or a distributor, that owned the product or equipment in the United States.

(4) This section in no way limits the liability of any manufacturer as defined in WAC 173-443-030 associated with a product or equipment from enforcement under chapter 70.94 RCW.

NEW SECTION

WAC 173-443-090 Initial notification. (1) By December 31, 2019, a manufacturer or its representative must provide ecology an initial status notification of the status of all products and equipment within each applicable end-use that contains, uses, or will use HFCs or other substitutes prohibited in WAC 173-443-040.

(2) An initial status notification must include all covered products and equipment that the manufacturer offers for sale, leases, rents, installs, or otherwise causes to enter into Washington commerce.

(3) A manufacturer must submit an initial status notification using ecology's notification form. The current form is available on ecology's website. This initial status notification must provide:

(a) Contact information on the manufacturer.

(b) The name of the party authorized to represent the manufacturer for purposes of providing initial status notifications and status updates.

(c) All products and equipment within an end-use that are applicable to the manufacturer.

(d) Which HFCs or other prohibited substitutes are being used by products or equipment within each applicable end-use.

(e) Signature and certification by the authorized representative for the manufacturer.

NEW SECTION

WAC 173-443-100 Status update notification. Within one hundred twenty days after the date of a prohibition in WAC 173-443-040, a manufacturer affected by the prohibition or its representative must provide ecology with an updated status notification using ecology's form. This updated status notification must include:

(1) Whether the manufacturer has ceased the use of HFCs or other substitutes prohibited in WAC 173-443-040 within each applicable end-use.

(2) What, if any, HFCs other prohibited substitutes remain in use.

(3) Updated responses on all information requested in the initial status notification required in WAC 173-443-090.

NEW SECTION

WAC 173-443-110 Severability. If any provision of this chapter or its application is held invalid, the remainder of the chapter or application of the provision is not affected.

WSR 20-13-096
PROPOSED RULES
DEPARTMENT OF RETIREMENT SYSTEMS

[Filed June 17, 2020, 9:21 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 20-09-045.

Title of Rule and Other Identifying Information: New WAC 415-02-160, postretirement employment during a period of emergency.

Hearing Location(s): On July 21, 2020, at 10:30 a.m.

The hearing will be conducted by telephone conference only: 360-407-3830 or 855-682-0796 (toll free).

Conference ID: 2312349.

Date of Intended Adoption: July 22, 2020.

Submit Written Comments to: Jilene Siegel, Department of Retirement Systems, P.O. Box 48380, Olympia, WA 98504-8380, email drs.rules@drs.wa.gov.

Assistance for Persons with Disabilities: Contact Jilene Siegel, phone 360-664-7291, TTY 711, email drs.rules@drs.wa.gov.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: To waive and suspend limits on postretirement employment during a period of emergency proclaimed by the governor under RCW 43.06.010(12).

Reasons Supporting Proposal: This section implements the Governor's Proclamation 20-39, suspending postretirement employment restrictions to allow public sector employers to retain or rehire experienced employees into critical positions necessary for an effective response to the COVID-19 pandemic.

Statutory Authority for Adoption: RCW 41.50.050.

Statute Being Implemented: RCW 41.50.050.

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

Name of Proponent: Department of retirement systems, governmental.

Name of Agency Personnel Responsible for Implementation: Seth Miller, Department of Retirement Systems, P.O. Box 48380, Olympia, WA 98504-8380, 360-664-7304.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. RCW 34.05.328 (5)(a)(i) does not apply to this proposed rule and is not voluntarily made applicable by the agency.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(3) as the rules relate only to internal governmental operations that are not subject to violation by a nongovernment party.

June 17, 2020
Jilene Siegel
Rules Coordinator

NEW SECTION

WAC 415-02-160 Will postretirement employment performed during a period of emergency affect my retirement benefit? During a period of emergency proclaimed by the governor under RCW 43.06.010(12) regarding the COVID-19 pandemic, and for which the governor has waived or suspended applicable statutory limitations, public service employment performed by a retiree shall not cause a suspension or reduction of retirement benefits.

For the purpose of this section, a "period of emergency" includes only the following: COVID-19 pandemic, for the period covered by the governor's proclamation.