WSR 21-09-055
PROPOSED RULES
DEPARTMENT OF
SOCIAL AND HEALTH SERVICES
(Developmental Disabilities Administration)
[Filed April 16, 2021, 11:01 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 20-09-150.

Title of Rule and Other Identifying Information: The department is proposing to amend chapter 388-826 WAC, Voluntary placement program.

Hearing Location(s): On June 8, 2021, at 10:00 a.m., at Office Building 2, Department of Social and Health Services (DSHS) Headquarters, 1115 Washington Street S.E., Olympia, WA 98501. 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 June 9, 2021.

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., June 8, 2021.

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 May 25, 2021.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposed amendments align with recent amendments to chapter 74.13 RCW, and align with new chapter 71A.28 RCW, Out-of-home services.

Reasons Supporting Proposal: These amendments are necessary to update the program from the voluntary placement services model to the way the program will now operate under chapter 71A.28 RCW, Out-of-home services.

Statutory Authority for Adoption: RCW 71A.12.030.

Statute Being Implemented: Chapters 71A.28, 74.13 RCW.

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

Name of Proponent: DSHS, governmental.

Name of Agency Personnel Responsible for Drafting: Chantelle Diaz, P.O. Box 45310, Olympia, WA 98504-5310, 360-407-1589; Implementation and Enforcement: Kacie Smarjesse, P.O. Box 45310, Olympia, WA 98504-5310, 360-407-1588.

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 Chantelle Diaz, P.O. Box 45310, Olympia, WA 98504-5310, phone 360-407-1589, fax 360-407-0955, TTY 1-800-833-6388, email Chantelle.Diaz@dshs.wa.gov.

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) because the rules do not affect small businesses.

Explanation of exemptions: The proposed amendments impose no new or disproportionate costs on small businesses, so a small business economic impact statement is not required.

April 15, 2021
Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 18-23-004, filed 11/7/18, effective 12/8/18)

WAC 388-826-0001 What are ((~~voluntary placement~~)) out-of-home services? ((~~Voluntary placement~~)) Out-of-home services are administered by the developmental disabilities administration (DDA) ((~~and~~)) through a person-centered service plan to provide ((~~temporary~~)) residential ((~~placement~~)) habilitation services for a child in a qualified setting outside of the child's ((~~regular~~)) home ((~~setting~~)) that is ((~~voluntarily~~)) agreed to by the child's parent((~~, custodian,~~)) or legal guardian ((~~and DDA~~)). Out-of-home services do not include educational services or care that is provided by other paid supports.

AMENDATORY SECTION (Amending WSR 18-23-004, filed 11/7/18, effective 12/8/18)

WAC 388-826-0005 What definitions apply to this chapter? "Child" means a person who is eligible under chapter 388-823 WAC for developmental disabilities administration (DDA) services ((~~under chapter 388-825 WAC~~)), under age eighteen, and in the custody of a parent ((~~by blood, adoption,~~)) or legal ((~~guardianship~~)) guardian.

"Child and family engagement plan" means a written agreement between the client's parent or legal guardian and the licensed or certified provider.

"Child foster home" means a private home licensed under chapter 110-148 WAC by the department of children, youth, and families (DCYF) to provide twenty-four hour care to children.

"Client" means a person eligible for DDA services under chapter ((~~388-825~~)) 388-823 WAC.

"Client responsibility" means the total amount of a client's participation and room and board.

"Community inclusion activities" means person-centered((~~, age appropriate, participation in~~)) activities where clients engage with others in ((~~a client's~~)) their local community.

"Custody" means:

(1) Protective care or guardianship of someone; or

(2) Parental responsibility, especially as allocated to one of two divorcing parents.

"DDA" means the developmental disabilities administration within the department of social and health services.

"Department" means the department of social and health services of the state of Washington.

"Family" means one or more of the following relatives: Spouse or registered domestic partner((~~,~~)); natural, adoptive,

or step parent; grandparent; child; stepchild; sibling; stepsibling; uncle; aunt; first cousin; niece; or nephew.

"Group care facility" means ((~~an agency, other than a foster family home, which~~)) a facility licensed under chapter 110-145 WAC by DCYF that is maintained and operated ((~~for the care of a group of children~~)) on a twenty-four hour basis to provide a safe and healthy living environment that meets the developmental needs of the children in care.

((~~**"Guardian ad litem (GAL)"** means a court-appointed neutral investigator whose job is to make a recommendation to the court if the proposed guardian is fit to serve and whether the client is legally incapacitated.~~

~~**"Judicial determination"** means a court process to determine whether out-of-home placement is in the best interest of a child.~~))

"Habilitation" means services delivered by a DCYF-licensed or DDA-certified provider that are intended to help a client acquire, retain, or improve upon the self-help, socialization, and adaptive skills necessary to reside successfully in a community-based setting.

"Individual instruction and support plan" means a written document that describes how staff will provide habilitation and supports to meet the needs identified in the client's person-centered service plan, which are assigned to and agreed upon by the out-of-home service provider.

"Legal guardian" means a person's legal guardian appointed through formal proceedings in accordance with state law.

((~~**"Legal status of the child"** means that the child is in legal custody of a biological or adoptive parent or legal and custodial guardian.~~

~~**"Out-of-home placement"** means a home other than the child's regular home, such as a state-operated living alternative or a facility licensed by the division of licensed resources (DLR) where the child has been placed.~~

~~**"Parent"** means a biological or adoptive parent who has legal responsibility for and physical custody of the child.~~))

"Out-of-home services acknowledgment" means a document signed by the client's parent or legal guardian acknowledging their custodial responsibility and decision making authority while the client is receiving services in a licensed or certified facility.

"Parent or legal guardian" means a biological or adoptive parent, guardian, or legal custodian with legal authority to make decisions on behalf of the child regarding healthcare and public benefits.

"Participation" has the same meaning as is under WAC 182-513-1100.

"Personal needs allowance (PNA)" means an amount set aside from a client's income under WAC 182-513-1105.

"Person-centered service plan (PCSP)" ((~~means a document that identifies the client's goals and assessed health and welfare needs. The person centered service plan also indicates the paid services and natural supports that will assist the client to achieve their goals and address their assessed needs~~)) has the same meaning as is under WAC 388-845-0001.

"Registered nurse delegator" means a licensed registered nurse who delegates specific nursing care tasks to a qualified nursing assistant or home care aide, and supports clients in a community-based care setting or in-home care setting under RCW 18.79.260.

"Residential habilitation services" means instruction and support services under WAC 388-845-1500.

"Respite care" means short-term, intermittent care to relieve a primary caregiver under WAC 388-845-1600.

"Room and board" has the same meaning as is under WAC 182-513-1100.

((~~**"Shared parenting"** means a collaboration between the parent or legal guardian and licensed provider or state-operated living alternative (SOLA) to share in meeting the support needs of the client receiving voluntary placement services.~~

~~**"Shared parenting plan"** means a written plan for sharing responsibilities among the parent, a licensed provider or SOLA and the department, outlining the shared responsibilities for care of a child.~~

~~**"Significant change assessment"** means an assessment triggered by an unexpected, documented change in a client's condition, activities of daily living, mood and behaviors, or psychological or medical conditions which affect the level of care needed for the client.~~))

"Significant change," as defined in WAC 388-832-0001, means a change in a client's medical condition, caregiver status, behavior, living situation, or employment status.

"SOLA" means a certified state-operated living alternative program.

"Staffed residential home," as defined in WAC 388-110-145-1305, means a licensed group care facility that provides twenty-four hour care to six or fewer children who require more supervision than can be provided in a foster home.

"Supplemental security income (SSI)" means a needs-based assistance program administered by the federal Social Security Administration for blind, disabled, and aged individuals.

((~~**"Voluntary placement agreement"** means a written agreement between the department and a child's parent, custodian, or legal guardian authorizing the department to place the child in a licensed facility or SOLA.~~))

"Treating professional" means a professional who specializes in the discipline within the professional's scope of practice.

"Wraparound planning" means a strengths-based process that includes regular meetings to review the client's individual instruction and support plan and ensure coordination with the client's team. The wraparound process is driven by the perspectives of the family and the child or youth.

AMENDATORY SECTION (Amending WSR 18-23-004, filed 11/7/18, effective 12/8/18)

WAC 388-826-0010 Who is eligible for ((~~voluntary placement~~)) out-of-home services? (((~~1~~))) A ((~~child~~)) client is eligible for ((~~voluntary placement~~)) out-of-home services if:

(((~~a~~))) (1) The ((~~child~~)) client:

(((~~i~~))) (a) Is ((~~DDA-eligible~~)) eligible for DDA services under chapter ((~~388-825~~)) 388-823 WAC;

(((~~(ii) Will enter voluntary out-of-home placement while under eighteen;~~)) (b) Is eligible for the core waiver under chapter 388-845 WAC, or roads to community living under WAC 182-513-1235;

(((~~(iii)~~))) (c) Has ((~~accessed all other available and appropriate DDA services~~)) received medically necessary inpatient treatment—when recommended by the client's treating professional—for conditions related to behavioral health or autism;

(((~~(b)~~))) (d) Will begin receiving out-of-home services before turning eighteen;

(e) Does not have a treatment recommendation for a locked or secure facility; and

(f) Is not:

(i) In the custody of the department of children, youth, and families under RCW 13.34.050 or 26.44.050;

(ii) In shelter care under RCW 13.34.060; or

(iii) A dependent in foster care under RCW 13.34.130;

(2) The ((~~child's~~)) client's parent((~~, guardian,~~)) or legal ((~~custodian~~)) guardian:

(((~~(i) Is unable to provide care for the child needs;~~

~~(ii) Has determined that the child would benefit from voluntary out-of-home placement;~~

~~(iii)~~))) (a) Has accessed available services the client is eligible for, including those available through private insurance, medicare, the medicaid state plan, and DDA;

(b) Requests out-of-home ((~~placement~~)) services solely because of the child's developmental disability; and

(((~~(iv) Requests voluntary placement services in writing;~~

~~(v) Complies with the voluntary placement agreement; and~~

~~(c) DDA:~~

~~(i) Has available funding;~~

~~(ii) Determines that available and appropriate in-home supports do not meet the child's needs;~~

~~(iii) Determines that voluntary out-of-home placement is in the child's best interest.~~

~~(2) The department considers voluntary out-of-home placement to be in the best interest of the child if voluntary placement services:~~

~~(a) Help maintain family relationships; and~~

~~(b) Provide the least restrictive setting that will benefit the child's medical, social, developmental, and personal needs.~~

~~(3) DDA waits to determine a client's eligibility for voluntary placement services until any pending child protective services' investigations conclude~~)) (c) Acknowledges and understands that enrollment in out-of-home services does not affect the legal rights and responsibilities of a client's parent or legal guardian.

AMENDATORY SECTION (Amending WSR 18-23-004, filed 11/7/18, effective 12/8/18)

WAC 388-826-0016 Where may a client receive ((~~voluntary placement~~)) out-of-home services? (1) A client may receive ((~~voluntary placement~~)) out-of-home services ((~~in~~)) from the following provider types:

(((~~(1)~~))) (a) A children's state-operated living alternative certified under this chapter; or

(((~~(2)~~))) (b) A home contracted with the developmental disabilities administration and licensed under chapter 74.15 RCW((~~, including~~)) as a:

(((~~(a)~~))) (i) Child foster home;

(((~~(b)~~))) (ii) Staffed residential home; or

(((~~(c)~~))) (iii) Group care facility for medically fragile children.

(2) To determine which type of provider will provide a client's out-of-home services, DDA:

(a) Assesses the amount of direct support necessary to meet the client's medical, social, developmental, and personal care needs; and

(b) Determines which provider type is the most cost-effective option that meets the unmet need identified in the client's person-centered service plan as required under WAC 388-845-0110.

NEW SECTION

WAC 388-826-0018 Does approval of out-of-home services affect a client's parental or custodial rights and responsibilities? (1) Enrollment in out-of-home services does not affect the legal rights and responsibilities of a client's parent or legal guardian.

(2) When a client enrolls in out-of-home services neither DSHS nor DDA takes custodial responsibility of the client.

NEW SECTION

WAC 388-826-0019 When must out-of-home services be terminated? Out-of-Home services must be terminated if:

(1) The client is receiving services in a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or other institution for thirty consecutive days or longer;

(2) The client's parent or legal guardian terminates services; or

(3) The client is over eighteen and terminates services.

AMENDATORY SECTION (Amending WSR 18-23-004, filed 11/7/18, effective 12/8/18)

WAC 388-826-0040 What is the ((~~voluntary placement agreement~~)) out-of-home services acknowledgment? (1) ((~~Before a child may enter voluntary out-of-home placement, the child's parent or legal guardian must execute a voluntary placement agreement~~)) The out-of-home services acknowledgment is a document signed by the client's parent or legal guardian acknowledging their custodial responsibility and decision making authority while the client is receiving services from a qualified provider.

(2) ((~~The voluntary placement agreement must specify~~)) An out-of-home services acknowledgment must state:

(a) ((~~That the child's parent or legal guardian retains legal custody of the child;~~

~~(b) That the department is responsible for the child's placement and care;~~

~~(c) That the signature of the child's parent or legal guardian is required;~~

~~(d) The legal status of the child;~~

~~(e) The rights and obligations of the parent or legal guardian;~~

~~(f) The rights and obligations of the child;~~

~~(g) The rights and obligations of the department while the child is in placement; and~~

~~(h) That any party to the voluntary placement agreement may terminate the agreement at any time.~~

~~(3) If a court has entered a final divorce decree or parenting plan that delineates decision-making authority, the parent must provide a copy of the document to the department.~~

~~(4) A voluntary placement agreement regarding an Indian child is invalid unless it complies with RCW 13.38.150.~~

~~(5) If a child's placement is unsuccessful under the terms of the voluntary placement agreement, the child returns to their parent's physical care until a new placement is available.~~

~~(6) Upon termination of the voluntary placement agreement, the child must return to the parent or legal guardian's care unless:~~

~~(a) Taken into custody under RCW 13.34.050 or 26.44.050;~~

~~(b) Placed in shelter care under RCW 13.34.060; or~~

~~(c) Placed in foster care under RCW 13.34.130~~)) DSHS and DDA are offering services through medicaid or roads to community living;

(b) The client is not a dependent of the state by enrolling in out-of-home services;

(c) Enrollment in out-of-home services does not affect the legal rights and responsibilities of the parent or legal guardian;

(d) The client's parent or legal guardian retains the authority to authorize medical care for the client;

(e) The client's parent or legal guardian retains the authority to make all legal decisions for the client;

(f) The client's parent or legal guardian continues to be legally responsible for caring for the client;

(g) The client's parent or legal guardian continues to be legally responsible for the client if out-of-home services are disrupted; and

(h) The client's parent or legal guardian continues to be legally responsible for the cost of the client's care, including room and board and basic expenses that are not covered by private insurance, medicare, the medicaid state plan, or other funding sources.

AMENDATORY SECTION (Amending WSR 18-23-004, filed 11/7/18, effective 12/8/18)

WAC 388-826-0041 What is a ((~~shared parenting~~)) child and family engagement plan? (1) A ((~~shared parenting~~)) child and family engagement plan is a written agreement between the client's parent or legal guardian((~~,~~)) and the ((~~licensed~~)) provider ((~~or SOLA, and the department~~)).

(2) ((~~The shared parenting~~)) A child and family engagement plan must:

(a) ((~~Include a plan for~~)) Outline the parent or legal guardian's ((~~continual involvement~~)) role while their child is receiving out-of-home services, including:

(i) A visitation schedule for ((~~visiting the child in out-of-home placement~~)) both the licensed or certified setting and family home;

(ii) ((~~An activities schedule~~)) Assistance in maintaining significant relationships to the child, such as transportation assistance and coordination; and

(iii) ((~~Emergency contact information;~~

~~(iv) Consent to medical care;~~

~~(v) Routine communication about medical issues, education, daily routines, and special considerations in the life of the child; and~~

~~(vi) Expectations for each party's role, including special considerations.~~)) Participation in attending medical and dental appointments, school meetings, and community inclusion activities;

(b) ((~~Coordinate health care benefits;~~

~~(c) Designate a representative payee;~~

~~(d) Address the requirement to access all available income sources under WAC 182-512-0700(1);~~

~~(e) Include a plan for respite care if the child lives in a child foster home~~)) Outline the provider's role, including:

(i) Supporting the client, parent, or legal guardian's cultural or religious practices;

(ii) Developing and implementing an individual financial plan under WAC 388-826-0042; and

(((~~f~~))) (iii) Celebrating holidays and special occasions;

(c) Be developed ((~~within forty-five days~~)) before the start date of the client's out-of-home ((~~placement and reviewed annually thereafter by the department.~~

~~(3) If any party does not follow the shared parenting plan, all parties must review and revise the shared parenting plan.~~

~~(4) If any party does not follow the revised shared parenting plan, DDA may terminate the client's voluntary placement services and the child will return to the parent or legal guardian's care unless:~~

~~(a) Taken into custody under RCW 13.34.050 or 26.44.050;~~

~~(b) Placed in shelter care under RCW 13.34.060; or~~

~~(c) Placed in foster care under RCW 13.34.130~~)) services;

(d) Be reviewed during the annual assessment or more frequently upon request; and

(e) Be updated when the client turns age eighteen to reflect the client's individualized transition goals, and legal guardianship if applicable.

NEW SECTION

WAC 388-826-0042 What is an individual financial plan? (1) An individual financial plan is a written agreement that delineates support needed in managing any portion of a client's funds by the provider.

(2) An individual financial plan is required when the child and family engagement plan indicates support is needed for the client to acquire money management skills.

(3) The provider must obtain signatures from the client's parent or legal guardian on the individual financial plan.

(4) The provider must include the following in the client's individual financial plan:

(a) Client funds and income managed by the provider;

(b) Client funds and income managed by the client;

(c) Client funds and income managed by the representative payee;

(d) The type of accounts containing client funds; and

(e) Money management instruction or support provided to the client.

(5) The provider must review the individual financial plan with the client's parent or legal guardian at least every twelve months.

(6) If the client is seventeen or younger, the provider must send a copy of the client's individual financial plan to:

(a) The client's parent or legal guardian; and

(b) The client's DDA case/resource manager or social service specialist.

(7) If the client is eighteen or older, the provider must send a copy of the client's individual financial plan to:

(a) The client;

(b) The client's parent or legal guardian if they have one; and

(c) The client's DDA case/resource manager or social service specialist.

NEW SECTION

WAC 388-826-0043 When must an individual instruction and support plan be developed or revised? (1) If a client is receiving out-of-home services in a staffed residential home or children's SOLA, the provider must develop and implement an individual instruction and support plan for each client they support.

(2) The provider must develop and implement a client's instruction and support plan no more than 30 days after the client begins receiving out-of-home services.

(3) The provider must revise a client's individual instruction and support plan:

(a) As goals are achieved or as the client's assessed needs change;

(b) At least semiannually; and

(c) If requested by the client or the client's parent or legal guardian.

NEW SECTION

WAC 388-826-0044 What requirements must the individual instruction and support plan meet? The individual instruction and support plan must:

(1) Describe habilitation goals that the provider and client will work on together while the provider supports the client;

(2) List the instruction and support activities the provider will provide to the client and explain how those activities meet the assessed needs identified in the client's person-centered service plan; and

(3) Describe other relevant support and service information.

AMENDATORY SECTION (Amending WSR 18-23-004, filed 11/7/18, effective 12/8/18)

WAC 388-826-0070 What are the department's responsibilities for a ((~~child~~)) client receiving ((~~voluntary placement~~)) out-of-home services? When a ((~~child~~)) client receives ((~~voluntary placement~~)) out-of-home services, the department must:

(1) ((~~Develop the shared parenting~~)) Facilitate the development of the child and family engagement plan ((~~no more than forty-five days after the child is placed out-of-home and review the plan~~)) under WAC 388-826-0041 before the start of service and at each annual assessment;

(2) Visit the ((~~child~~)) client in their ((~~out-of-home placement~~)) licensed or certified setting at least every ninety days;

(3) ((~~Review~~)) Develop the ((~~child's~~)) client's person-centered service plan ((~~no more than ninety days after the child is placed out-of-home~~)) as required under WAC 388-845-3055;

(4) Assist families to access a client's medically necessary physical or behavioral health benefits, which may include attending care conferences and sharing information with medicare, medicaid, or private health insurance representatives for purposes of care coordination;

(5) Monitor the ((~~child's voluntary placement~~)) client's out-of-home services by:

(a) Facilitating team meetings using a wraparound planning model;

(b) Reviewing the ((~~child's~~)) individual instruction and support ((~~plans~~)) plan;

(c) Reviewing the quarterly report;

(d) Reviewing incident reports and follow-up measures involving the client;

(((~~(d)~~))) (e) Authorizing payment for services; ((~~and~~

~~(e) Facilitating communication between the client's parent, legal guardian, and licensed provider or SOLA;~~

~~(5)~~))) (f) Completing annual quality assurance assessments of staffed residential providers and children's state-operated living alternative providers; and

(g) Contracting with evaluators to complete certification evaluations of children's state-operated living alternative providers.

(6) Determine eligibility for ((~~apple health~~)) medicaid coverage under chapters 182-513 and 182-515 WAC;

(((~~(6)~~))) (7) Determine the ((~~child's~~)) client's participation and room and board amount, if any;

(((~~(7) Comply with the permanency planning hearing requirements under RCW 13.34.270 no more than one-hundred eighty days after the child is placed out-of-home and annually thereafter;~~)))

(((~~(8) Notify the child's parent or legal guardian in writing before the date of each annual permanency planning hearing;~~

~~(9)~~))) (8) Monitor the ((~~licensed~~)) provider ((~~or SOLA~~)) to ensure the provider complies with contract requirements, which includes compliance with DDA policies ((~~and minimum licensing rules~~)); and

(((~~(10)~~))) (9) Refer a client ((~~age eighteen or older~~)) for a nurse delegation assessment by a registered nurse delegator, if ((~~necessary~~)) requested by the provider.

AMENDATORY SECTION (Amending WSR 18-23-004, filed 11/7/18, effective 12/8/18)

WAC 388-826-0071 What are the responsibilities of the licensed or certified provider supporting a client receiving ((~~voluntary placement~~)) out-of-home services? (1) When a client is receiving ((~~voluntary placement~~)) out-of-home services, the licensed or certified provider must:

(((~~(1)~~))) (a) Ensure the health and safety of the client;

(b) Provide adequate staff to meet the needs of clients as identified in the rate assessment;

(c) Meet the requirements of each contract entered into with the department;

(d) Develop and implement an individual instruction and support plan, unless the client is receiving out-of-home services from a child foster home provider or a group care facility for medically fragile children;

(e) Complete quarterly reports under subsection (2) or subsection (3) of this section;

(f) Participate in the development of the child and family engagement plan with the client, the client's parent or legal guardian, and social service specialist;

(g) Implement the child and family engagement plan;

(h) Support the client in regular school attendance, including following the school's reporting requirements when the client is absent or has an appointment during the school day;

(i) Participate in the client's individualized education program;

(j) Attend all school-related meetings;

(k) With the parent or legal guardian's consent, maintain regular communication with school representatives;

(l) Maintain regular communication with the client's parent or legal guardian;

(m) Develop evacuation plans in case of fire, natural disaster, or other emergencies in accordance with:

(i) WAC 110-145-1670 for staffed residential and group care facilities for medically fragile children; or

(ii) WAC 110-148-1460 for child foster homes;

(n) Maintain a client rights policy in accordance with chapter 71A.26 RCW;

(o) If the client is in a staffed residential home or children's SOLA:

(i) Discuss and schedule community inclusion activity options with the client; and

(ii) Track, and make available to the department upon request, the client's participation in community inclusion activities, including:

(A) Date of each activity;

(B) Cost of each activity; and

(C) A running balance of the client's community inclusion activities funds;

(p) Request an assessment for nurse delegation if the client needs medication administration.

(2) ((~~Develop a~~)) Quarterly ((~~report if the client is in a staffed residential home or group care facility for medically fragile children. The quarterly report~~)) reports from a staffed residential provider, a children's SOLA, or group care facility for medically fragile children must ((~~include~~)):

(a) Be submitted to DDA and sent to the client's parent or legal guardian no more than ten business days after the end of each quarter; and

(b) Include:

(i) A summary of the client's progress toward ((~~developing skills~~)) habilitation goals identified in the ((~~individualized treatment~~)) individual instruction and support plan;

(((~~(b)~~))) (ii) An update regarding ((~~shared parenting~~)) the child and family engagement plan, including a summary of family visits;

(((~~(c)~~))) (iii) A summary of incident reports, if any;

(((~~(d)~~))) (iv) School progress, including individualized education program updates;

(((~~(e)~~))) (v) Any significant changes in the client's condition or prescribed medications; and

(((~~(f)~~))) (vi) A summary of the client's participation in community inclusion activities.

(3) ((~~Help develop and implement the shared parenting plan;~~

~~(4) Participate in the client's individualized education program;~~

~~(5) Develop emergency preparedness plans under WAC 110-145-1670;~~

~~(6) Track, and make available to the department upon request, the client's participation in community inclusion activities - if the client is in a staffed residential home - including:~~

~~(a) Date of each activity;~~

~~(b) Cost of each activity; and~~

~~(c) A running balance of the client's community inclusion activities funds;~~

~~(7) Retain all client records for at least six years after termination or expiration of their contract; and~~

~~(8) Request an assessment for nurse delegation if the client is age eighteen or older and needs medication administration~~)) Quarterly reports from a child foster home provider must:

(a) Be submitted to DDA and sent to the client's parent or legal guardian no more than ten business days after the end of each quarter; and

(b) Include:

(i) The client's progress toward their habilitation goal;

(ii) A list of community and other activities the client has participated in;

(iii) An update regarding the child and family engagement plan, including a summary of family visits;

(iv) School progress, including individualized education program updates; and

(v) Any significant changes in the client's condition or prescribed medications.

AMENDATORY SECTION (Amending WSR 18-23-004, filed 11/7/18, effective 12/8/18)

WAC 388-826-0072 What training must ((~~a licensed~~)) direct care staff of a staffed residential ((~~or SOLA employee~~)) home complete? To provide direct support to a client receiving ((~~voluntary placement~~)) out-of-home services, ((~~a licensed~~)) direct care staff of a staffed residential ((~~or SOLA employee~~)) home must complete:

(1) Training required under chapter 110-145 WAC;

(2) Training and continuing education required under chapter 388-829 WAC;

(3) Client-specific training based on the ((~~client's treatment plan and person-centered service~~)) individual instruction and support plan; and

(4) Nurse delegation training under chapter 246-888 WAC, if applicable.

NEW SECTION

WAC 388-826-0073 What training must a child foster home provider complete? To support a client receiving out-of-home services, a child foster home provider must complete:

(1) Training required to maintain licensing under chapter 110-148 WAC; and

(2) Nurse delegation training under chapter 246-888 WAC, if applicable.

NEW SECTION

WAC 388-826-0074 What training must a children's state-operated living alternative provider complete? (1) To provide direct support to a client receiving out-of-home services, a children's state-operated living alternative provider must complete:

(a) Training and continuing education required under chapter 388-829 WAC;

(b) Training required under WAC 388-101D-0090 through WAC 388-101D-0110; and

(c) Nurse delegation training under chapter 246-888 WAC, if applicable.

(2) The provider must ensure that each employee providing direct support keeps their first-aid training, CPR certification, food worker card, and bloodborne pathogens training current.

AMENDATORY SECTION (Amending WSR 20-02-101, filed 12/31/19, effective 2/1/20)

WAC 388-826-0075 What are a parent or legal guardian's responsibilities ((~~when a child is receiving voluntary placement~~)) while the client receives out-of-home services? (((~~(1) When~~)) While a client ((~~is receiving voluntary placement~~)) receives out-of-home services, the client's parent or legal guardian must:

(((~~(a)~~))) (1) Maintain weekly contact with the child and actively participate in care planning;

(((~~(b) Comply with the voluntary placement agreement;~~

~~(c)~~))) (2) Participate in the development and ongoing assessment of the client's individual educational plan and maintain regular communication with the provider and school representatives;

(3) Coordinate all medically necessary physical or behavioral health benefits available through private insurance, medicare, or the medicaid state plan;

(4) Apply for ((~~all~~)) income and benefits available to the child; ((~~and~~

~~(d)~~))) (5) Participate in:

(((~~(i)~~))) (a) The ((~~shared parenting~~)) development and implementation of the child and family engagement plan;

(((~~(ii)~~))) (b) Team meetings; and

(((~~(iii)~~))) (c) The DDA annual assessment, including the person-centered service plan((~~.~~

~~(2) When the child receives social security income, the child's parent or legal guardian must establish a representative payee to manage the child's income and comply with the client responsibility and basic expenses required in this chapter.~~

~~(3) Nonpayment of a child's client responsibility or basic expenses may jeopardize the child's placement with a provider~~)); and

(6) Establish a representative payee to manage the client's social security or supplemental security income and comply with the client responsibility and basic expenses required in this chapter.

(7) Ensure payment of the client responsibility or basic expenses. Nonpayment may jeopardize the client's services with a provider.

AMENDATORY SECTION (Amending WSR 18-23-004, filed 11/7/18, effective 12/8/18)

WAC 388-826-0077 ((~~Who is eligible for~~)) May a client who is receiving out-of-home services also receive respite services? (1) A client ((~~who lives in a foster home is~~)) receiving out-of-home services in a child foster home may be eligible for respite services under chapter 388-828 WAC.

(2) A client ((~~who lives~~)) receiving out-of-home services in a ((~~licensed~~)) staffed residential, children's SOLA, or group home for medically fragile children is not eligible for respite services.

(((~~(3) The DDA assessment under chapter 388-828 WAC determines the amount of respite services a client may receive.~~)))

AMENDATORY SECTION (Amending WSR 18-23-004, filed 11/7/18, effective 12/8/18)

WAC 388-826-0078 Who may provide respite services to a client receiving ((~~voluntary placement~~)) out-of-home services in a child foster home? To provide respite services to a client receiving ((~~voluntary placement~~)) out-of-home services in a child foster home, a provider must:

(1) Be a qualified provider under WAC 388-845-1615; and

(2) Have a respite contract with the developmental disabilities administration.

AMENDATORY SECTION (Amending WSR 18-23-004, filed 11/7/18, effective 12/8/18)

WAC 388-826-0079 What limits apply to respite services? The respite limits under WAC 388-845-1620 apply to a client receiving ((~~voluntary placement~~)) out-of-home services in a child foster home.

AMENDATORY SECTION (Amending WSR 20-02-101, filed 12/31/19, effective 2/1/20)

WAC 388-826-0095 What must a client pay toward the cost of ((~~voluntary placement~~)) out-of-home services in a ((~~licensed~~)) staffed residential home, a children's SOLA, or a group care facility? (1) To receive ((~~voluntary placement~~)) out-of-home services in a ((~~licensed~~)) staffed residential home, a children's SOLA, or a group care facility for medically fragile children, a client may be required to pay client responsibility as required under this section.

(2) The department determines the amount of client responsibility and room and board a client must pay under:

(a) WAC 182-515-1510 if the client is enrolled on a DDA home and community-based ((~~(HCB)~~)) services (HCBS) waiver under chapter 388-845 WAC; or

(b) WAC 182-513-1235 if the client is enrolled in roads to community living under chapter 388-106 WAC.

AMENDATORY SECTION (Amending WSR 20-02-101, filed 12/31/19, effective 2/1/20)

WAC 388-826-0096 What must a client pay toward the cost of ((~~voluntary placement~~)) out-of-home services in a child foster home? (1) To receive ((~~voluntary placement~~)) out-of-home services in a child foster home, a client must pay the provider a fixed monthly amount referred to as basic expenses, which must be outlined in a basic expense agreement.

(2) The written basic-expense agreement must include:

(a) Monthly amounts for rent, utilities, and food costs; and

(b) The day of the month the payment is due to the provider.

(3) The total monthly obligation in the basic-expense agreement must not exceed the client's available income minus the personal needs allowance under WAC 182-513-1105(5).

(4) Before the client moves into the child foster home, the basic-expense agreement must be:

(a) Signed by the ((~~client or the~~)) client's parent or legal ((~~representative~~)) guardian;

(b) Signed by the provider; and

(c) Sent to DDA.

(5) Changes to the basic-expense agreement must be reviewed by DDA before implementation.

AMENDATORY SECTION (Amending WSR 20-02-101, filed 12/31/19, effective 2/1/20)

WAC 388-826-0097 What expenses must a parent or legal guardian pay for while their child receives ((~~voluntary placement~~)) out-of-home services? A parent or legal guardian remains financially responsible for all expenses for their minor child that are not included in ((~~voluntary placement~~)) out-of-home services.

AMENDATORY SECTION (Amending WSR 20-02-101, filed 12/31/19, effective 2/1/20)

WAC 388-826-0098 What does the department pay toward ((~~voluntary placement~~)) out-of-home services? (1) For a client residing in a ((~~licensed~~)) staffed residential home, a children's ((~~state-operated living alternative (SOLA)~~)) SOLA, or a group care facility for medically fragile children, the department pays the cost of the ((~~voluntary placement~~)) out-of-home services minus the amount of client responsibility under WAC 388-826-0095.

(2) For a client residing in a child foster home, the department pays the cost of the ((~~voluntary placement~~)) out-of-home services minus basic expenses under WAC 388-826-0096.

AMENDATORY SECTION (Amending WSR 18-23-004, filed 11/7/18, effective 12/8/18)

WAC 388-826-0130 How does the department determine the rate to support a client in a ((~~licensed~~)) child foster home? (1) The department determines the rate that is paid to support a client in a ((~~licensed~~)) child foster home by conducting a child foster ((~~care~~)) home rate assessment.

(2) DDA conducts the child foster ((~~care~~)) home rate assessment((~~:~~

~~(a) No more than thirty days after the date the child is admitted to a licensed foster home;~~

~~(b) Annually; and~~

~~(c) If a significant change occurs~~)) with the child foster home provider before out-of-home services begin.

AMENDATORY SECTION (Amending WSR 18-23-004, filed 11/7/18, effective 12/8/18)

WAC 388-826-0133 What is the representative payee's role? The representative payee:

(1) Manages the client's social security or supplemental security income;

(2) Uses the client's income to contribute toward the cost of the client's participation and room and board;

(3) Places the client's personal needs allowance and any conserved funds in a payee account; and

(4) Monitors the child's payee account to maintain eligibility for supplemental security income ((~~(SSI)~~)) and medicaid.

AMENDATORY SECTION (Amending WSR 18-23-004, filed 11/7/18, effective 12/8/18)

WAC 388-826-0138 What questions are in the child foster ((~~care~~)) home rate assessment and how are ((~~answers~~)) responses scored? (1) The child foster ((~~care~~)) home rate assessment consists of thirteen questions.

(2) Scores are based on the parent or legal guardian's report, natural supports available, documented support plans (e.g., nursing, physical therapy, occupational therapy), and report of care provided by the ((~~licensed~~)) child foster home provider.

(3) The assessment excludes any additional paid supports provided, such as nursing and therapies.

(4) The hours are assessed against the number of hours expected to support a typically developing child the same age as the client.

(5) Daily living: What is the average number of hours per day spent supporting the client with daily living tasks like dressing, grooming, toileting, feeding and providing specialized body care? Do not include private duty nursing hours in this average.

Hours per day	Score
0 to 1	30
2 to 5	91
6 to 9	213
10 to 20	396
Over 20	609

(6) Physical needs: What is the average number of hours per day spent providing assistance to the client that is not included in the "daily living" category above? Examples include assistance with: Mobility; prosthetics; communication; other assistive devices; airway management (monitors, ventilators); pressure sores; and enteral nutrition. Do not include private duty nursing hours in this average.

Hours per day	Score
0 to 1	30
2 to 5	91
6 to 20	274
Over 20	609

(7) Behavioral needs: What is the average number of hours per day spent providing behavioral, emotional, and mental health supports to the client? Do not include hours under subsection (8)(b) of this section in this average.

Hours per day	Score
0 to 1	30
2 to 5	91
6 to 13	335
14 to 24	578
Over 24	731

(8) Therapeutic plan: What is the average number of hours per week spent implementing a plan prescribed by a professional related to the child's physical, behavioral, emotional, or mental health therapy? The foster parent must provide a copy of each plan to the assessor.

(a) What is the average number of hours per week spent providing or attending physical, occupational, and speech therapy?

Hours per week	Score
0 to 1	4
2 to 3	13
4 to 9	30
10 to 46	65
Over 46	390

(b) What is the average number of hours per week spent participating in or implementing services identified in the client's behavioral support plan, such as applied behavior analysis (ABA) or counseling?

Hours per week	Score
0 to 1	4
2 to 3	13
4 to 19	48
20 to 60	104
Over 60	390

(9) Appointments: What is the average number of hours per week spent scheduling, traveling to and from, and participating in appointments? The foster parent must provide documentation of appointments to the assessor.

(a) What is the average number of hours per week spent scheduling, traveling to and from, and participating in doctor visits, dental visits, rehabilitation, and therapy visits?

Hours per week	Score
0 to 1	4
2 to 5	13
6 to 14	39
Over 14	82

(b) What is the average number of hours per week spent scheduling, traveling to and from, and participating in community activities, such as recreation, leisure, sports, and extra-curricular activities?

Hours per week	Score
0 to 1	4
2 to 3	13
4 to 7	30
8 to 20	48
Over 20	130

(10) House care: What is the average number of times per week spent repairing, cleaning, and replacing household items and medical equipment, over and above normal wear and tear, due to:

(a) A chronic medical condition?

Times per week	Score
0 to 1	6
2 to 7	24
8 to 19	58
20 to 38	91
Over 38	238

(b) Destructive behavior?

Times per week	Score
0 to 1	6
2 to 3	15
4 to 9	28
10 to 22	58
Over 22	162

(11) Development and socialization skills: What is the average number of hours per week spent providing guidance and assistance?

(a) What is the average number of hours per week spent helping with homework and learning new activities?

Hours per week	Score
0 to 1	4
2 to 3	13
4 to 11	30
12 to 30	87
Over 30	249

(b) What is the average number of hours per week spent interacting with other professionals, such as meeting with teachers, visiting the client's school, speaking on the phone with school personnel, participating in individual education plan development and review?

Hours per week	Score
0 to 1	4
2 to 3	13
4 to 5	22
6 to 12	30
Over 12	82

(c) What is the average number of hours per week spent developing socialization and functional life skills, like making positive choices, being accountable, managing money, exploring the community, and relating to peers, adults, and family members?

Hours per week	Score
0 to 1	4
2 to 7	22
8 to 19	56
20 to 60	173
Over 60	403

(12) ((~~Shared parenting~~)) Child and family engagement plan: What is the average number of hours per week spent ((~~implementing the shared parenting~~)) coordinating the child and family engagement plan? The ((~~shared parenting~~)) plan must be available for review by the assessor.

Hours per week	Score
0 to 1	4
2 to 3	13
4 to 12	30
Over 12	82

AMENDATORY SECTION (Amending WSR 18-23-004, filed 11/7/18, effective 12/8/18)

WAC 388-826-0145 How does DDA determine the ((~~foster care~~)) assessed level from the raw score in the child foster home rate assessment? (1) The following are the ((~~foster care~~)) assessed levels based on the range of aggregate scores:

Level	Low Score	High Score
1	0	320
2	321	616
3	617	1501
4	1502	2085
5	2086	2751
6	2752	9999999

(2) A standardized rate for ((~~specialized~~)) out-of-home services is assigned to levels one through six.

(3) The standardized rate is published by DDA and is paid monthly to the child foster ((~~parent~~)) home provider.

AMENDATORY SECTION (Amending WSR 18-23-004, filed 11/7/18, effective 12/8/18)

WAC 388-826-0150 What happens if a client who is receiving out-of-home services in a child foster home experiences a significant change ((~~assessment occurs~~))? (1) If a client who is receiving out-of-home services in a child foster home experiences a significant change ((~~assessment occurs~~)), DDA conducts:

(a) A reassessment under WAC 388-828-1500; and

(b) A child foster ((~~care~~)) home rate assessment.

(2) If the child foster ((~~care~~)) home rate assessment results in a rate change, the foster parent receives a thirty-day written notice that includes the effective date of the change.

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

AMENDATORY SECTION (Amending WSR 18-23-004, filed 11/7/18, effective 12/8/18)

WAC 388-826-0160 Are child foster ((~~care~~)) home rates appealable? A child foster ((~~care~~)) home rate is not appealable through the administrative hearing process.

AMENDATORY SECTION (Amending WSR 18-23-004, filed 11/7/18, effective 12/8/18)

WAC 388-826-0170 How does the department determine the rate to support a client in a ((~~licensed~~)) staffed residential home? (1) ((~~To determine~~)) The department determines the rate to support a client in a ((~~licensed~~)) staffed residential home((~~, the department assesses~~)) by assessing the client's ((~~support~~)) identified needs((~~, including:~~)).

(2) The department completes a rate assessment, which consists of four cost centers:

(a) Administrative and nonstaff costs, including transportation and damage reimbursement, if applicable;

(b) Funds for community inclusion activities as outlined in WAC 388-826-0005;

(c) Consultant and training costs; and

(d) Instruction and support services, which are determined by assessing a client's identified needs and supervision in the following areas:

(i) Activities of daily living as defined in WAC 388-106-0010;

(((~~b~~))) (ii) Instrumental activities of daily living as defined in WAC 388-106-0010; and

(((~~c~~))) (iii) Behavioral support and supervision ((~~supports~~)).

((~~(2) Children are entitled to appropriate educational services including, to the extent possible, participating in a full school day. The department must not pay a provider for any hours the client is in school~~)) (3) Instruction and support services provided by the school district are not included in the rate assessment to support a client in a staffed residential home.

(4) A rate assessment must be completed before start of services, if a significant change occurs, or when the household composition changes.

AMENDATORY SECTION (Amending WSR 18-23-004, filed 11/7/18, effective 12/8/18)

WAC 388-826-0175 ((~~How~~)) What does the department ((~~determine the rate to support a medically fragile client in~~)) pay a group care facility for medically fragile children that is providing out-of-home services to a client? (1) To support a client receiving out-of-home services in a group care facility for medically fragile children, the department pays ((~~a group care facility~~)) the provider a DDA-established, per-person, monthly rate ((~~to support a medically fragile client~~)).

(2) Out-of-home services must not replace or duplicate services or benefits available through private insurance, medicare, or the medicaid state plan.

AMENDATORY SECTION (Amending WSR 18-23-004, filed 11/7/18, effective 12/8/18)

WAC 388-826-0200 What happens if a licensed provider terminates a client's out-of-home ((~~placement~~)) services? (1) If a licensed provider terminates a client's out-of-home ((~~placement~~)) services, the provider must:

((~~(1) The child must return to the parent or legal guardian's care unless:~~

~~(a) Taken into custody under RCW 13.34.050 or 26.44.050;~~

~~(b) Placed in shelter care under RCW 13.34.060; or~~

~~(c) Placed in foster care under RCW 13.34.130;~~

~~(2) The provider must:~~))

(a) Notify the client's parent or legal guardian, the department, and the client's school in writing at least thirty days before the termination; ((~~and~~))

(b) ((~~Develop~~)) Provide one of the following termination reasons:

(i) The provider cannot meet the needs of the client;

(ii) The client's safety or the safety of other people in the home or facility is endangered;

(iii) The client's health or the health of other people in the home or facility would otherwise be endangered; or

(iv) The provider ceases to operate; and

(c) Participate in the development of a transition plan((~~; and~~

~~(3)~~)).

(2) If a licensed provider terminates a client's out-of-home services, the department assesses the client's health and welfare needs((~~,~~)) and ((~~may authorize supports to the family while a new out-of-home placement is identified~~)) authorizes services within the scope of the home and community-based services waiver identified in the client's person-centered service plan.

AMENDATORY SECTION (Amending WSR 18-23-004, filed 11/7/18, effective 12/8/18)

WAC 388-826-0205 What happens when a client, parent, or legal guardian requests a different provider? (1) A client, parent, or legal guardian requesting a change in provider must((~~:~~

~~(a)~~)) notify the DDA social ((~~worker~~)) service specialist and provider((~~; and~~

~~(b) Determine if current services can be modified to meet the client's need~~)).

(2) ((~~If services cannot be modified to meet the client's need, alternative residential options may be explored~~)) DDA will work with the parent or legal guardian to determine whether the parent or legal guardian's concerns can be addressed with the current provider.

(3) If the parties do not come to a resolution:

(a) The client may return to the family home until a ((~~new placement~~)) qualified residential service provider is identified; or

(b) The client may remain ((~~in~~)) with the current ((~~placement~~)) provider until ((~~a new~~)) another qualified provider is ((~~identified~~)) selected by the parent or legal guardian.

((~~(3) The department may request a court review and a guardian ad litem to represent the best interest of the child.~~))

AMENDATORY SECTION (Amending WSR 18-23-004, filed 11/7/18, effective 12/8/18)

WAC 388-826-0230 ((~~What happens after a client turns~~)) When may a client age eighteen or older continue to receive out-of-home services? A client ((~~who turns eighteen while in voluntary~~)) age eighteen or older may continue

receiving out-of-home ((~~placement may remain there until their twenty-first birthday~~)) services if the client is:

(1) ((~~They pursue a high school or equivalency course of study (GED/HSEC) or vocational program~~)) Under the age of twenty-one;

(2) ((~~A voluntary placement agreement is signed by the client or their legal guardian~~)) Receiving out-of-home services the day before their eighteenth birthday; and

(3) ((~~The client can self-administer medication or they receive nurse delegation services~~)) Pursuing a high school or equivalency course of study (GED/HSEC) or vocational program.

NEW SECTION

WAC 388-826-0231 What is initial certification? (1) Initial certification is a document issued by DDA that indicates a children's state-operated living alternative provider meets the requirements under this chapter to deliver out-of-home services.

(2) The provider must obtain initial certification no more than ninety days after the first date of service delivery.

(3) The provider must allow a DDA-contracted evaluator to complete an on-site certification evaluation.

(4) Based on the findings of the certification evaluation, DDA may issue:

(a) Initial certification; or

(b) Provisional certification.

(5) An initial certification is valid for no more than twelve months.

NEW SECTION

WAC 388-826-0232 What is standard certification? (1) Standard certification is a document issued by DDA that indicates a children's state-operated living alternative provider meets the requirements under this chapter to deliver out-of-home services.

(2) The provider must obtain standard certification before their initial certification expires.

(3) The provider must allow a DDA-contracted evaluator to complete an on-site certification evaluation.

(4) Based on the findings of the evaluation, DDA may:

(a) Issue standard certification;

(b) Issue provisional certification; or

(c) Decertify the provider.

(5) A standard certification is valid for no more than twenty-four months.

NEW SECTION

WAC 388-826-0233 What is provisional certification? (1) DDA may impose a provisional certification for a maximum of ninety days if the children's state-operated living alternative provider:

(a) Prevents or interferes with a certification evaluation or complaint investigation by DSHS;

(b) Fails to comply with chapter 388-826 WAC;

(c) Fails to comply with chapter 74.34 RCW or chapter 26.44 RCW;

(d) Knowingly makes a false statement of material fact to DSHS; or

(e) Fails to implement a plan of correction.

(2) At the end of the provisional certification, if the provider has complied with certification requirements, DDA may approve the provider for standard certification.

(3) At the end of the provisional certification, if the provider has not complied with certification requirements, DDA must decertify the provider.

NEW SECTION

WAC 388-826-0234 What must a children's state-operated living alternative provider comply with to maintain certification? To maintain certification, a children's state-operated living alternative provider must comply with:

(1) Requirements under this chapter;

(2) Laws governing this chapter, including chapter 71A.12 RCW;

(3) Requirements under chapter 74.34 RCW;

(4) Other relevant federal, state and local laws, requirements, and ordinances.

NEW SECTION

WAC 388-826-0235 What if a children's state-operated living alternative provider disagrees with a certification evaluation or certification decision? If a children's state-operated living alternative provider disagrees with a certification evaluation or certification decision under this chapter, the provider may request an informal dispute resolution meeting with DDA by:

(1) Submitting a written request to DDA no more than ten days after receiving the final certification letter and report; and

(2) Including a written statement that identifies the challenged action, describes the provider's concerns, and lists regulations and standards cited.

NEW SECTION

WAC 388-826-0236 When may DDA decertify a children's state-operated living alternative provider? DDA may decertify a children's state-operated living alternative provider who:

(1) Has had a certification, medicaid or medicare provider agreement denied, suspended, revoked, not renewed, or terminated for noncompliance with state or federal regulations;

(2) Obtained or attempted to obtain a certification or contract by fraudulent means or misrepresentation; or

(3) Willfully prevented or interfered with or failed to cooperate with any investigation or certification evaluation made by the department or DDA-contracted evaluator, including refusal to permit authorized department representatives to interview clients or have access to their records.

NEW SECTION

WAC 388-826-0237 How must the children's state-operated living alternative provider participate in the

certification evaluation process? The children's state-operated living alternative provider must participate in the certification evaluation process with DDA employees and DDA-contracted evaluators by:

(1) Allowing scheduled and unscheduled visits;

(2) Providing information and documentation as requested;

(3) Cooperating in setting up appointments;

(4) Responding to questions or issues identified;

(5) Participating in an exit conference; and

(6) Submitting a corrective action plan within an agreed time frame, if applicable.

AMENDATORY SECTION (Amending WSR 18-23-004, filed 11/7/18, effective 12/8/18)

WAC 388-826-0240 Who may appeal a department action? (((~~(1)~~))) A client, the client's parent, or the client's ((~~authorized representative~~)) legal guardian may appeal ((~~any decision~~)) an action under ((~~RCW 71A.10.050~~)) chapter 182-526 WAC or WAC 388-825-120.

(((~~(2) A request may be made orally or in writing.~~

~~(3) An appellant must request an administrative hearing no more than ninety days after the date they received notification of the disputed decision.~~

~~(4) An appellant must request an administrative hearing within the ten-day notice period under WAC 388-458-0040 if the client wishes to receive continued benefits under WAC 388-825-145.~~))

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 388-826-0011	What do voluntary placement services include?
WAC 388-826-0050	What are the judicial requirements for a child receiving voluntary placement services?

WSR 21-10-004
WITHDRAWAL OF PROPOSED RULES
LIQUOR AND CANNABIS BOARD
(By the Code Reviser's Office)
[Filed April 22, 2021, 12:28 p.m.]

WAC 314-55-101, 314-55-1011, 314-55-102, 314-55-1021, 314-55-1022, and 314-55-1025, proposed by the liquor and cannabis board in WSR 20-20-040, appearing in issue 20-20 of the Washington State Register, which was distributed on October 21, 2020, 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 21-10-005
WITHDRAWAL OF PROPOSED RULES
OFFICE OF FINANCIAL MANAGEMENT
(By the Code Reviser's Office)
[Filed April 22, 2021, 12:38 p.m.]

WAC 357-31-215, proposed by the office of financial management in WSR 20-20-083, appearing in issue 20-20 of the Washington State Register, which was distributed on October 21, 2020, 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 21-10-007
WITHDRAWAL OF PROPOSED RULES
OFFICE OF THE INSURANCE COMMISSIONER
(By the Code Reviser's Office)
[Filed April 22, 2021, 12:42 p.m.]

WAC 284-43-6560, proposed by the office of the insurance commissioner in WSR 20-20-123, appearing in issue 20-20 of the Washington State Register, which was distributed on October 21, 2020, 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 21-10-018
PROPOSED RULES
OFFICE OF FINANCIAL MANAGEMENT
[Filed April 23, 2021, 1:32 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 19-16-028.

Title of Rule and Other Identifying Information: WAC 357-01-210 Nonpermanent appointment, 357-04-015 Who is not covered by civil service rules?, 357-04-020 May the director exempt other positions from civil service?, 357-04-025 What rights does a classified employee have when the position the employee holds is exempted from the civil service rules?, 357-04-030 What right does an employee have to return to the classified service from exempt service?, 357-04-035 Who defines exempt status for student employees, temporary employees, and part-time professional consultants for higher education employers?, 357-04-045 Which temporary employees of higher education employers are exempt from civil service rules?, 357-04-046 May a higher education

employer make subsequent appointments for temporary employees who have exhausted their temporary appointment as identified in WAC 357-04-045?, 357-04-055 Who defines exempt status for student or temporary employees; part-time professional consultants; and inmates for general government employers and what types of positions are exempt?, 357-19-360 For what reasons may an employer make nonpermanent appointments?, 357-19-365 When is it inappropriate for an employer to fill a position with a nonpermanent appointment to address a short-term immediate workload peak or other short term needs?, 357-19-370 How long may a nonpermanent appointment last?, 357-19-373 What notification must an employer give a nonpermanent appointee?, 357-19-376 May an employee receive consecutive higher education nonpermanent appointments?, 357-19-377 What provisions apply to nonpermanent appointments?, 357-19-385 May a permanent employee accept a nonpermanent appointment?, 357-19-388 What notices must employees and their employers provide each other when an employee accepts a nonpermanent appointment?, 357-19-400 May an employer convert a nonpermanent appointment to a probationary or trial service appointment?, 357-19-420 What are the appeal rights of nonpermanent employees?, 357-19-425 How does a nonpermanent employee request remedial action?, 357-19-430 When may the director take remedial action for nonpermanent employees and what does remedial action include?, 357-19-435 For what reasons may a higher education employer appoint an individual to a temporary appointment?, 357-19-440 What provisions govern higher education temporary appointments?, and 357-19-450 When may the director take remedial action for individuals in higher education temporary appointments and what does remedial action include?

Hearing Location(s): On June 10, 2021, at 8:30 a.m., at the office of financial management (OFM), audio conference only, Dial-in (888) 285-8919, Enter pin 8101730, Code (if asked) 415.

Date of Intended Adoption: June 17, 2021.

Submit Written Comments to: Brandy Chinn, OFM, P.O. Box 47500, Olympia, WA 98501, email Brandy.Chinn@ofm.wa.gov, fax 360-586-4694, by June 3, 2021.

Assistance for Persons with Disabilities: OFM, TTY 711 or 1-800-833-6384, by June 3, 2021.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Aligns the civil service rules with amendments to RCW 41.06.070 by removing part-time employees from being exempt from the civil service; only temporary employees as defined by OFM are now exempt from civil service laws. The proposed rules also redefine temporary higher education appointments and expand the current general government nonpermanent rules to institutions of higher education.

Reasons Supporting Proposal: To align Title 357 WAC with the requirements in RCW 41.06.070.

Statutory Authority for Adoption: Chapter 41.06 RCW.

Statute Being Implemented: RCW 41.06.070.

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

Name of Proponent: [Not supplied by agency], governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: Brandy Chinn, 128 10th Avenue, Olympia, WA 98501, 360-878-2901.

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. Rules are related to internal government operations and are not subject to violation by a nongovernmental party. See RCW 34.05.328 (5)(b)(ii) for exemption.

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.

April 23, 2021
Roselyn Marcus
Assistant Director of
Legal and Legislative Affairs

AMENDATORY SECTION (Amending WSR 05-01-204, filed 12/21/04, effective 7/1/05)

WAC 357-01-210 Nonpermanent appointment. An appointment made by ((~~a general government~~)) an employer under the provisions of WAC 357-19-360.

AMENDATORY SECTION (Amending WSR 05-01-203, filed 12/21/04, effective 7/1/05)

WAC 357-04-015 Who is not covered by civil service rules? The civil service rules do not apply to positions specifically exempted in individual agency statutes, chapter 41.06 RCW, and to the following:

(1) Washington state patrol trooper cadets in training for commissioning as troopers in the Washington state patrol;

(2) The executive director, ((~~his/her~~)) the executive director's confidential secretary, assistant directors, and professional education employees of the state board for community and technical colleges; and

(3) Inmate, student, ((~~part-time,~~)) or temporary employees, and part-time professional consultants, as defined by the ((~~Washington personnel resources board~~)) director in WAC 357-04-040, 357-04-045, 357-04-050, and 357-04-055.

AMENDATORY SECTION (Amending WSR 05-01-203, filed 12/21/04, effective 7/1/05)

WAC 357-04-020 May the director exempt other positions from civil service? The director may provide for further exemptions for general government positions involving substantial responsibility for formulating basic agency or executive policy or involving directing and controlling program operations of an agency or a major administrative division of an agency in accordance with the provisions and procedures of RCW 41.06.070((~~(3)~~)).

AMENDATORY SECTION (Amending WSR 05-01-203, filed 12/21/04, effective 7/1/05)

WAC 357-04-025 What rights does a classified employee have when the position ((~~he/she~~)) the employee holds is exempted from the civil service rules? As required by RCW 41.06.070((~~(3)~~)) and 41.06.170, an employee holding a classified position has the following rights if the position is exempted from the application of the civil service rules:

(1) If the employee previously held permanent status in another classified position, the employee has the right to return to the highest class of position previously held, or to a position of similar nature and salary in accordance with WAC 357-19-220.

(2) The employee may appeal the exemption of the position in accordance with chapter 357-52 WAC.

AMENDATORY SECTION (Amending WSR 06-15-067, filed 7/13/06, effective 8/14/06)

WAC 357-04-030 What right does an employee have to return to the classified service from exempt service? As required by RCW 41.06.070((~~(3)~~)), any employee having permanent status in a classified position who accepts an appointment in an exempt position has the right to return to classified service in accordance with WAC 357-19-195, 357-19-200, and 357-19-205. As long as the employee was not terminated from the exempt position for gross misconduct or malfeasance, the employee has the right to return to the highest class of position in which ((~~he/she~~)) the employee previously held permanent status or to a position of similar nature and salary.

AMENDATORY SECTION (Amending WSR 04-15-016, filed 7/8/04, effective 7/1/05)

WAC 357-04-035 Who defines exempt status for student((~~, part-time, or~~)) employees, temporary employees, and part-time professional consultants for higher education employers? In accordance with RCW 41.06.070, the ((~~board~~)) director defines exemptions for student((~~, part-time or~~)) employees, temporary employees, and part-time professional consultants. Higher education employers must use the definitions in WAC 357-04-040, 357-04-045, and 357-04-050 as the criteria for identifying positions in these categories of employment that are exempt from civil service rules.

AMENDATORY SECTION (Amending WSR 10-11-021, filed 5/10/10, effective 6/10/10)

WAC 357-04-045 Which ((~~part-time or~~)) temporary employees of higher education employers are exempt from civil service rules? ((~~Persons employed to work one thousand fifty hours or less in a twelve consecutive month period from the original date of hire or October 1, 1989, whichever is later, are exempt from civil service rules.~~)) (1) Temporary higher education employees are exempt from civil service rules under the following circumstances:

(a) The employee is employed twelve consecutive months or less;

(b) The employee is employed for one thousand fifty hours or less in that same twelve consecutive month period which begins from the original date of hire or January 1, 2022, whichever is later; and

(c) The employee is limited to one appointment only with the same higher education employer that meets the criteria in (a) and (b) of this subsection.

(2) Temporary appointments under the provisions of this section are subject to remedial action in accordance with WAC 357-19-450.

(3) Temporary employees who are ((~~either~~)) exempt under ((~~this~~)) subsection ((~~or exceptions authorized under WAC 357-19-440,~~)) (1) of this section and who work more than three hundred fifty hours in a twelve consecutive month period from the original date of hire or January 1, 2004, whichever is later, may be included in an appropriate bargaining unit for purposes of collective bargaining, as determined by the public employment relations commission. Overtime and time worked as a student employee under the provisions of WAC 357-04-040 are not counted in the three hundred fifty hours. For purposes of counting the three hundred fifty hours, the twelve-month period will begin on the employee's original date of hire or January 1, 2004, whichever is later. ((~~The next twelve-month period will repeat accordingly. For example:~~

~~The employee's original date of hire is June 1, 2009. The twelve-month period would be June 1, 2009, through May 31, 2010. The next twelve-month period would be June 1, 2010, through May 31, 2011. This pattern will continue.~~

~~Once the employee works at least three hundred fifty hours in a job classification in the collective bargaining unit the employee remains in that collective bargaining unit until the end of the first twelve-month period (as described in this section) in which the employee does not work at least three hundred fifty hours in a job classification that is in the collective bargaining unit. An employee who has not worked sufficient hours in a bargaining unit job classification to remain in the bargaining unit, is excluded from the bargaining unit until the employee again works at least three hundred fifty hours in a bargaining unit job classification in a twelve-month period (as described in this section).~~

~~Temporary appointment under the provisions of this section may be subject to remedial action in accordance with WAC 357-19-450, if the number of hours worked exceeds one thousand fifty hours in a twelve consecutive month period from the original date of hire or October 1, 1989, whichever is later. Overtime and time worked as a student employee under the provisions of WAC 357-04-040 are not counted in the one thousand fifty hours. For purposes of counting the one thousand fifty hours, the twelve month period will begin on the employee's original date of hire or October 1, 1989, whichever is later. The next twelve-month period will repeat accordingly. For example:~~

~~The employee's original date of hire is June 1, 2009. The twelve-month period would be June 1, 2009, through May 31, 2010. The next twelve-month period would be June 1, 2010, through May 31, 2011. This pattern will continue.~~))

NEW SECTION

WAC 357-04-046 May a higher education employer make subsequent appointments for temporary employees who have exhausted their temporary appointment as identified in WAC 357-04-045? Higher education employers may hire employees who have exhausted their temporary appointment as identified in WAC 357-04-045 if the employee is appointed as a nonpermanent or permanent employee in accordance with chapter 357-19 WAC.

AMENDATORY SECTION (Amending WSR 04-15-016, filed 7/8/04, effective 7/1/05)

WAC 357-04-055 Who defines exempt status for student((~~, part-time,~~)) or temporary employees; part-time professional consultants; and inmates for general government employers and what types of positions are exempt? In accordance with RCW 41.06.070, the ((~~board~~)) director defines exemptions for student((~~, part-time~~)) or temporary employees; part-time professional consultants; and inmates. The following types of general government employees are exempt from civil service rules:

(1) Part-time local health officers;

(2) ((~~Persons employed on a part-time, or temporary basis for medical, nursing or other professional service and who are not engaged in the performance of administrative duties;~~

~~(3) Part-time or~~)) Temporary employees who are enrolled as full-time students in recognized educational institutions and whose employment is largely to provide a training opportunity, and all temporary employees not in federal grant-in-aid programs;

(((~~(4)~~))) (3) Patient and resident help in general government residential facilities;

(((~~(5)~~))) (4) Inmate help in general government correctional facilities; and

(((~~(6)~~))) (5) Skilled and unskilled labor employed temporarily on force account; construction and maintenance projects; or employed on temporary seasonal single phases of agricultural production or harvesting; or as determined by the director to be equivalent.

AMENDATORY SECTION (Amending WSR 05-01-206, filed 12/21/04, effective 7/1/05)

WAC 357-19-360 For what reasons may ((~~a general government~~)) an employer make nonpermanent appointments? ((~~A general government~~)) An employer may fill a position with a nonpermanent appointment when any of the following conditions exist:

(1) A permanent employee is absent from the position;

(2) The ((~~agency~~)) employer is recruiting to fill a vacant position with a permanent appointment;

(3) The ((~~agency~~)) employer needs to address a short-term immediate workload peak or other short-term needs;

(4) The ((~~agency~~)) employer is not filling a position with a permanent appointment due to the impending or actual layoff of a permanent employee(s); or

(5) The nature of the work is sporadic and does not fit a particular pattern.

AMENDATORY SECTION (Amending WSR 05-01-206, filed 12/21/04, effective 7/1/05)

WAC 357-19-365 When is it inappropriate for ((~~a general government~~)) an employer to fill a position with a nonpermanent appointment to address a short-term immediate workload peak or other short-term needs? ((~~General government~~)) Employers **must not** fill a position with a nonpermanent appointment under the provisions of WAC 357-19-360(3) when the work of the position is scheduled, ongoing and permanent in nature. If at any time during a nonpermanent appointment, a short-term workload peak or other short term need becomes ongoing and permanent in nature, the employer must take action to fill the position on a permanent basis.

AMENDATORY SECTION (Amending WSR 05-01-206, filed 12/21/04, effective 7/1/05)

WAC 357-19-370 How long ((~~can a general government~~)) may a nonpermanent appointment last? (1) ((~~Agencies~~)) Employers are encouraged to limit the duration of a nonpermanent appointment to twelve months from the appointment date.

(2) A nonpermanent appointment for a reason specified in WAC 357-19-360 (1) through (4) **must not** exceed twenty-four months unless the director has approved an extension of the appointment due to the continued absence of a permanent employee. An employer may choose to not count time spent in formal training programs towards the twenty-four month limit. On-the-job training is not considered a formal training program for purposes of this rule.

AMENDATORY SECTION (Amending WSR 05-01-206, filed 12/21/04, effective 7/1/05)

WAC 357-19-373 What notification must ((~~a general government~~)) an employer give a nonpermanent appointee? (1) Upon appointment, all nonpermanent appointees must be notified in writing of the conditions of their appointment and/or upon any subsequent change to the conditions of their appointment.

(2) The written notification must at a minimum contain the following information:

(a) The reason for the nonpermanent appointment in accordance with WAC 357-19-360;

(b) The hours of work and the base salary;

(c) The anticipated short-term duration or sporadic nature of the appointment;

(d) A statement regarding the receipt or nonreceipt of benefits. If the employee is to receive benefits, the statement shall include which benefits are to be received; and

(e) The right to request remedial action as provided in WAC 357-19-425.

NEW SECTION

WAC 357-19-376 May an employee receive consecutive higher education nonpermanent appointments? Individuals may receive consecutive nonpermanent appointments

as long as any subsequent appointment is to a different position.

AMENDATORY SECTION (Amending WSR 05-01-206, filed 12/21/04, effective 7/1/05)

WAC 357-19-377 What provisions apply to ((~~general government~~)) nonpermanent appointments? ((~~General government~~)) Nonpermanent appointments are subject to the following provisions:

(1) Nonpermanent appointees must meet the competencies and other requirements of the position to which they are appointed.

(2) Nonpermanent appointments may be filled on a noncompetitive basis which means the employer is not required to comply with the rules on recruitment, assessment((,)) and certification as provided in chapter 357-16 WAC.

(3) Nonpermanent appointments may be filled using the competitive process specified in chapter 357-16 WAC as long as the eligible applicant indicates a willingness to accept a nonpermanent appointment.

(4) ((~~Agencies~~)) Employers may underfill a position with a nonpermanent appointment.

AMENDATORY SECTION (Amending WSR 05-01-206, filed 12/21/04, effective 7/1/05)

WAC 357-19-385 ((~~Can~~)) May a permanent employee accept a nonpermanent appointment? A permanent employee may accept a ((~~general government~~)) nonpermanent appointment.

AMENDATORY SECTION (Amending WSR 05-12-077, filed 5/27/05, effective 7/1/05)

WAC 357-19-388 What notices must employees and their employers provide each other when an employee accepts a nonpermanent appointment? Employees who accept a nonpermanent appointment must give their current employers at least fourteen calendar days' notice before moving to a nonpermanent appointment. The current ((~~agency~~)) employer and employee may agree to waive or shorten the notice period.

When the current employer receives the employee's notice, the employee's permanent ((~~agency~~)) employer must notify the employee in writing of ((~~his/her~~)) the employee's return right at the conclusion of the nonpermanent appointment.

For purposes of this rule, written notice may be provided using alternative methods such as email, campus mail, the state mail service, or commercial parcel delivery in accordance with WAC 357-04-105.

AMENDATORY SECTION (Amending WSR 06-15-066, filed 7/13/06, effective 8/14/06)

WAC 357-19-400 ((~~Can the agency~~)) May an employer convert a ((~~general government~~)) nonpermanent appointment to a probationary or trial service appointment? (1) When an ((~~agency~~)) employer uses a competitive process to make a nonpermanent appointment to fill a position in the absence of a permanent employee or fill a position nonpermanently due to the impending or actual layoff of a permanent employee(s), the ((~~agency~~)) employer may change the status of the appointment to probationary or if the employee held permanent status prior to the nonpermanent appointment to trial service if:

(a) The permanent employee does not return to the position or the layoff action has been implemented; and

(b) The ((~~agency~~)) employer needs to fill the position permanently.

(2) At the discretion of the appointing authority, time spent in the nonpermanent appointment may count towards the probationary or trial service period for the permanent position.

AMENDATORY SECTION (Amending WSR 05-01-206, filed 12/21/04, effective 7/1/05)

WAC 357-19-420 What are the appeal rights of ((~~general government~~)) nonpermanent employees? Employees without permanent status appointed to ((~~general government~~)) nonpermanent appointments have no appeal rights with the exception of remedial action as provided in WAC 357-19-430.

AMENDATORY SECTION (Amending WSR 05-01-206, filed 12/21/04, effective 7/1/05)

WAC 357-19-425 How does a ((~~general government~~)) nonpermanent employee request remedial action? Requests for remedial action by nonpermanent employees must be received in writing within thirty days as provided in chapter 357-49 WAC. Following a director's review of the remedial action request, an employee may file exceptions to the director's decision in accordance with chapter 357-52 WAC.

AMENDATORY SECTION (Amending WSR 05-01-206, filed 12/21/04, effective 7/1/05)

WAC 357-19-430 When may the director take remedial action for ((~~general government~~)) nonpermanent employees and what does remedial action include? The director may take remedial action to confer permanent status, set base salary, and establish seniority when it is determined that the following conditions exist:

(1) The employer has made an appointment that does not comply with rules on nonpermanent appointment; or

(2) The duration of a nonpermanent appointment as defined in WAC 357-19-360 (1) through (4) has exceeded twenty-four months without director approval.

AMENDATORY SECTION (Amending WSR 05-01-192, filed 12/21/04, effective 7/1/05)

WAC 357-19-435 For what reasons may a higher education employer ((~~make~~)) appoint an individual to a temporary appointment? A higher education employer may ((~~make~~)) appoint an individual to a temporary appointment for the following reasons:

(1) The number of hours to be worked by the individual will not exceed one thousand fifty hours in ((~~any~~)) a twelve consecutive month period from the original date of hire or ((~~October 1, 1989~~)) January 1, 2022, whichever is later, in accordance with WAC 357-04-045; or

(2) The employing official formally assigns a classified employee the duties and responsibilities of a higher-level class for a period of less than six consecutive months. In accordance with WAC 357-19-441(2), temporary appointments under this subsection are not exempt from civil service rules.

AMENDATORY SECTION (Amending WSR 05-01-192, filed 12/21/04, effective 7/1/05)

WAC 357-19-440 What provisions govern higher education temporary appointments? (1) Temporary appointments may be made without regard to rules on recruitment, assessment((~~,~~)) and certification as provided in chapter 357-16 WAC.

(2) Each higher education employer must develop for director approval a procedure which indicates the employer's system for controlling and monitoring ((~~exempt part-time and~~)) temporary positions as identified in WAC 357-04-045. The procedure must include a mechanism to access and report hours worked by an individual temporary employee.

(3) ((~~A higher education employer may petition the director in writing for approval of exceptions to the one thousand fifty hours threshold as specified in WAC 357-19-435 (1).~~

~~(4)~~)) No temporary appointment shall take the place of employees laid off under the provisions of WAC 357-46-010.

AMENDATORY SECTION (Amending WSR 05-01-192, filed 12/21/04, effective 7/1/05)

WAC 357-19-450 When may the director take remedial action for individuals in higher education temporary appointments and what does remedial action include? For individuals in higher education temporary appointments under the provisions of WAC 357-19-435(1), the director may take remedial action to confer permanent status, set base salary((~~,~~)) and establish seniority when it is determined that the following conditions exist:

(1) The ((~~employee~~)) individual has worked in one or more temporary positions as identified in WAC 357-04-045 for more than one thousand fifty hours in any twelve consecutive month period since the original hire date or ((~~October 1, 1989~~)) January 1, 2022, whichever is later. (Overtime and time worked as a student employee under the provisions of WAC 357-04-040 are not counted in the one thousand fifty hours.)

(2) The position or positions are subject to civil service.

(3) The employee has not taken part in any willful failure to comply with these rules.

WSR 21-10-023
PROPOSED RULES
DEPARTMENT OF REVENUE
[Filed April 26, 2021, 1:14 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 21-03-054.

Title of Rule and Other Identifying Information: WAC 458-61A-1001 Graduated real estate excise tax rates—Exceptions to graduated rates—Disregarded transactions.

Hearing Location(s): On June 8, 2021, at 10:00 a.m. This meeting will be conducted over the internet and telephone. Contact Keith Dacus, management analyst, at KeithD@dor.wa.gov for login/dial-in information.

Date of Intended Adoption: June 22, 2021.

Submit Written Comments to: Brenton Madison, P.O. Box 47453, Olympia, WA 98504-7453, email BrentonM@dor.wa.gov, fax 360-534-1606, by June 11, 2021.

Assistance for Persons with Disabilities: Contact Julie King or Renee Cosare, phone 360-704-5733 or 360-704-5734, TTY 800-833-6384.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: This new rule will explain the real estate excise tax graduated rates provided in RCW 82.45.060, as well as explain the exceptions to the application of graduated tax rates, which are covered in RCW 82.45.060(3). The rule will also explain circumstances under which the department will disregard the form of a transaction per RCW 82.45.235.

Reasons Supporting Proposal: Provides taxpayers the guidance regarding the real estate excise tax in light of the passage of ESSB 5998 (2019).

Statutory Authority for Adoption: RCW 82.01.060, 82.45.060, and 82.45.235.

Statute Being Implemented: RCW 82.45.060 and 82.45.235.

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: None.

Name of Proponent: Department of revenue, governmental.

Name of Agency Personnel Responsible for Drafting: Brenton Madison, 6400 Linderson Way S.W., Tumwater, WA, 360-534-1583; Implementation and Enforcement: John Ryser, 6400 Linderson Way S.W., Tumwater, WA, 360-534-1605.

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 rule is not a significant legislative rule as defined by RCW 34.05.328.

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 does not impose more-than-minor costs on businesses, as it does not propose any new requirements not already provided for in statute. The proposed rule does not impose fees,

filing requirements, or recordkeeping requirements that are not already established in statute.

April 26, 2021
Atif Aziz
Rules Coordinator

NEW SECTION

WAC 458-61A-1001 Graduated real estate excise tax rates—Exceptions to graduated rates—Tax avoidance arrangements. (1) **Introduction.** This rule explains how the graduated real estate excise tax rates apply to transactions subject to real estate excise tax (REET). See chapter 82.45 RCW. The rule also explains when and how the tax rates change over time. In addition to the REET discussed in this rule, a sale of real property may also be subject to an excise tax imposed by a county or city. See RCW 82.46.010.

(2) **Other rules that may apply.** Readers may want to refer to other rules for additional information, including:

(a) WAC 458-30-200 Definitions.

(b) WAC 458-61A-100 Real estate excise tax—Overview.

(c) WAC 458-61A-101 Taxability of the transfer or acquisition of the controlling interest of an entity with an interest in real property located in this state.

(d) WAC 458-61A-102 Definitions.

(e) WAC 458-61A-301 Payment of tax, collection responsibility, audit responsibility, and tax rulings.

(f) WAC 458-61A-303 Affidavit.

(g) WAC 458-61A-306 Date of sale, interest, and penalties.

(3) **Examples.** This rule includes examples that identify a number of facts and then state a conclusion. These examples should only be used as a general guide. The tax results of other situations must be determined after a review of all the facts and circumstances.

(4) **Definitions.** In addition to the definitions found in chapter 82.45 RCW, the following definitions apply throughout this section.

(a) **"Agricultural land"** means "farm and agricultural land" and "farm and agricultural conservation land," as those terms are defined in RCW 84.34.020, including any structures affixed to the land. Affixed structures may include fences, irrigation systems, machinery, or other types of property, dependent upon the determinative factors under Washington law:

(i) Actual annexation of the realty, or something appurtenant thereto;

(ii) Application to the use or purpose to which that part of the realty with which it is connected is appropriated; and

(iii) The intention of the party making the annexation to make a permanent accession to the freehold. See *Dep't of Revenue v. Boeing*, 85 Wn.2d 663, 538 P.2d 505 (1975).

(b) **"Classified land"** refers to land falling under this rule's definitions for "agricultural land" or "timberland."

(c) **"Consumer price index for shelter"** means the most current seasonally adjusted index for the shelter expenditure category of the consumer price index for all urban consumers (CPI-U) as published by July 31st of each year by the United States Department of Labor, Bureau of Labor Statistics.

(d) **"Growth of the consumer price index for shelter"** means the percentage increase in the consumer price index for shelter for the most recent three-year period for the selling prices threshold adjustment in 2022, and the most recent four-year period for the subsequent selling price threshold adjustments.

(e) **"Meaningful purpose"** means, apart from its tax benefits, a bona fide and significant reason for structuring a transaction in a certain way, such as a substantial increase in profit or reduction in cost.

(f) **"Nonclassified land"** refers to land that is not "classified land."

(g) **"Substantial nontax reason"** means a bona fide nontax reason that is a substantial motivating factor to the taxpayer's decision to enter into the arrangement or transaction in this state. A bona fide nontax reason may include the purpose of obtaining tax benefits from another government, provided the benefits are not the same type, kind, or nature of any substantial Washington state tax benefit obtained under the arrangement or transaction.

(h) **"Timberland"** means land classified under chapter 84.34 RCW or designated under chapter 84.33 RCW, including structures and timber on timberland, as well as timber sold apart from the timberland. The term generally means any parcel of land that is five or more acres, or multiple parcels of land that are contiguous and total five or more acres, and devoted primarily to the growth and harvest of timber for commercial purposes. The term includes land used for incidental uses that are compatible with growing and harvesting timber, but no more than ten percent of the land may be used for such incidental uses. Timberland includes the land on which appurtenances necessary for the production, preparation, or sale of the timber products exist in conjunction with land producing these products. The term, however, does not include a residential homesite.

(5) **Graduated tax rates and thresholds.**

(a) For the period of January 1, 2020, through June 30, 2022, the selling price of a sale of real property, except as provided in subsection (7) of this rule, is subject to the real estate excise tax at the following tax rates (state portion only):

(i) 1.1 percent of the portion of selling price less than or equal to $500,000;

(ii) 1.28 percent of the portion of the selling price greater than $500,000 and less than or equal to $1,500,000;

(iii) 2.75 percent of the portion of the selling price greater than $1,500,000 and less than or equal to $3,000,000; and

(iv) 3 percent of the portion of the selling price greater than $3,000,000.

(b) Effective July 1, 2022, and every fourth year thereafter, the tax rate thresholds increase by the same percentage as the growth of the "consumer price index for shelter," but not more than 5 percent.

(6) **Determining the proper tax rate(s).**

(a) **Deeded transfers.** Graduated tax rates are determined according to the total selling price of a sale of real property. "Selling price" means the true and fair value of the

property conveyed, which is presumed to be the total consideration paid to the transferor in an arm's length transaction between unrelated persons for a valuable consideration. See WAC 458-61A-102. Real property conveyed in an arm's length transaction between unrelated persons for a valuable consideration may include more than one parcel of real property. See RCW 82.45.030(1).

In cases where a sale includes parcels of real property located in more than one county, a separate real estate excise tax affidavit must be filed with each county, however, the selling price for purposes of the graduated tax rates is unaffected. For more information on completing affidavits see WAC 458-61A-303.

Example 1. Single arm's length transaction.

Facts: Sam Moore has owned three separate but adjacent retail parcels located in Thurston County for several years. Mr. Moore decides to sell all three of the parcels, which share a parking lot, and lists/markets the properties as a single sale. Mr. Moore agrees to sell the properties to Michelle Smith. The sale occurs on June 1, 2020, with a total selling price of $1,000,000 for the three parcels of real property. Individually each property is valued by the Thurston County assessor at $250,000, $275,000, and $375,000 respectively.

Result: The total selling price for determining the applicable tax rate is $1,000,000.

Example 2. Separate arm's length transactions.

Facts: Assume the facts from example 1, except that Mr. Moore separately markets and lists each parcel of real property for sale. During the month of June 2020, Mr. Moore receives three separate offers for each parcel of real property, which he accepts. The purchaser of each property is a separate unrelated party. Mr. Moore is unrelated to each of the buyers and each of the sales are completed at arm's length. The selling price of each parcel of real property is $300,000, $300,000, and $400,000.

Result: Mr. Moore made three separate sales of real property. The REET rate applicable to each sale is determined by the selling price of each parcel of real property.

Example 3. Single arm's length transaction (property located in multiple counties).

Facts: Anna Carter owns and leases two buildings to the same lessee, which the lessee uses to operate his nail salon businesses located in Yelm, Washington and Roy, Washington. Rather than list the properties for sale with an agent, Ms. Carter decides to sell both properties to the lessee, James Wright. The sale occurs on August 1, 2020, and the selling price is $900,000.

Result: For purposes of determining the applicable tax rate, Ms. Carter must use the total selling price of $900,000 when applying the tax rate thresholds. Because the sale involves real property parcels located in multiple counties, a separate affidavit must be filed with each county.

(b) **Controlling interest transfers.** For purposes of determining the applicable real estate excise tax rate(s), the selling price means the true and fair value of the real property owned by the entity at the time the controlling interest is transferred. See WAC 458-61A-101(4) for more information on the measure of tax for controlling interest transfers.

(7) **Sales of real property classified as agricultural land or timberland.** The sale of real property classified as either "agricultural land" or "timberland," is subject to a nongraduated REET rate of 1.28 percent. In instances where a sale includes both "agricultural land" or "timberland" and nonclassified land, the predominant use of the real property determines the applicable tax rate. RCW 82.45.060.

(a) **Predominant use factors.** Predominant use is determined by two equal factors:

(i) Square footage factor; and

(ii) County-assessed value factor (value factor).

(b) **Predominant use calculation.** Real property is predominantly used as classified land if the classified portion of the property accounts for at least 50 percent of the average of the square footage and county-assessed value. The determination is computed as follows:

(i) Divide the square footage of classified land by the square footage of all real property included in the sale.

(ii) Divide the county-assessed value of classified land by the county-assessed value of all real property included in the sale.

(iii) Add the calculated value in (b)(i) of this subsection to the calculated value in (b)(ii) of this subsection, then divide the sum by two.

(iv) If the result is equal to or greater than 0.5, all of the real property included in the sale is treated as classified land subject to the flat rate of 1.28 percent. If the result is less than 0.5, all of the real property included in the sale is treated as nonclassified land subject to the graduated tax rates.

(c) **Land classification based on continued land use.** For purposes of Title 84 RCW, Property taxes, sales of real property that include classified land require determinations of whether the buyer intends to continue using the property in a manner required for classification of the property as classified land. Buyers reflect their land use intentions for this purpose on a notice of continuance. County assessors determine whether the land will continue to be primarily used as classified land.

Thus, in cases where a county assessor indicates the buyer's intended use of classified land reflects continued use of the land as agricultural land or timberland, the seller will treat the real property as agricultural land or timberland for purposes of determining the predominant use of real property included in the sale.

In cases where the county assessor indicates the buyer's intended use would remove the property from the agricultural land or timberland classification, the real property is nonclassified land for purposes of determining its predominant use for REET purposes.

Real property is only treated as classified land if:

(i) The buyer indicates it will continue to use the land in a qualifying manner; and

(ii) The county assessor approves the land for such continued use.

(iii) If the conditions in (c)(i) and (ii) of this subsection are not met, the seller must report the real property as nonclassified land for purposes of determining the applicable tax rate.

Example 4. Real property sale involving classified and nonclassified land - Predominantly classified land.

Facts: A real property sale of 2 parcels of real property, Parcel A and Parcel B. The selling price is $1,500,000. Parcel

A is classified land (agricultural land) and Parcel B is nonclassified land. Parcel A is 3,600,000 square feet. Parcel B is 400,000 square feet. The county assessed value of Parcel A is $150,000. The county assessed value of Parcel B is $1,100,000. The real property's predominant use is determined as follows:

1. Square footage factor: 0.90 (3,600,000 sq. ft. (classified land)/4,000,000 sq. ft. (total square footage of Parcel A and Parcel B)).

2. Value factor: 0.12 ($150,000 (county-assessed value of Parcel A)/$1,250,000 (county-assessed value of Parcels A and B)).

3. **Predominant use determination:** 0.51 ((0.90 + 0.12) /2).

Result: The predominant use of the property sold is for a classified purpose. If the buyer intends to continue using the land in a qualifying manner and the county assessor approves the real property for continued designation as classified land, the sale is subject to a flat tax rate of 1.28 percent. The tax liability is $25,600.

(8) **Disregarding the form of certain arrangements designed to avoid tax.** RCW 82.45.235 authorizes the department to disregard the form of a transaction or series of transactions to determine the proper REET treatment based on the substance of the transaction or transactions. Among other actions, the department may treat a single sale as multiple sales or treat multiple sales as a single sale.

(a) Factors for disregarding the form of a transaction(s). When necessary to deny the tax benefit that would otherwise accrue from engaging in one or more related transactions designed to avoid tax under this chapter, the department is authorized to disregard the form of the transaction or series of transactions and determine the proper tax treatment based on the substance of the transaction or transactions. In exercising this authority, the department may consider the factors described in RCW 82.32.655 (2)(a), (b), (c), and (f):

(i) Whether an arrangement or transaction changes in a meaningful way, apart from its tax effects, the economic positions of the participants when the transaction is considered as a whole;

(ii) Whether substantial nontax reasons exist for entering into a transaction;

(iii) Whether a transaction is a reasonable means of accomplishing a substantial nontax purpose; and

(iv) Other relevant factors.

(b) **Result of a disregarded transaction(s).** For transactions occurring on or after January 1, 2020, in cases where the department disregards the form of a transaction(s), the department will determine the amount of tax properly due based on the actual substance of the transaction(s). See WAC 458-61A-306(6) and 458-20-228 (5)(f) for information on instances where the department may apply an evasion penalty if a tax deficiency results from an intent to evade tax.

Example 5. Tax avoidance - Series of sales of a partial interest in a single parcel of real property.

Facts: In February 2020, Prime Office Inc. (Prime) agrees to buy a large office building in Seattle for $3,500,000 from King Commercial Inc. (King). In order to pay the lowest rate of tax, the parties agree to structure the sale as seven separate sales of a one-seventh interest in the parcel of real property, each with a selling price of $500,000 (1/7 x $3,500,000). The sales are completed and recorded during the month of February 2020. As a result of the arrangement, the total real estate excise tax paid on the transactions is $38,500 (1.1% tax rate x $3,500,000).

Result: The department will disregard the reported form of the separate transactions and treat the arrangement as a single sale, with a selling price of $3,500,000. As a result, the proper amount of tax due for the transaction is $74,550. The department will assess $36,050 in additional real estate excise tax.

Example 6. Tax avoidance - Multiple owners of a single real property parcel - Individual interests sold separately.

Facts: Juan and Li are business partners who each own a 50 percent interest in an LLC that owns one residential property in Washington. Juan and Li agree to sell the residential property to an unrelated third party, Mike, for $1,000,000. In order to reduce the amount of real estate excise tax due on the transaction, prior to completing the sale, Juan and Li each redeem their 50 percent interest in the LLC for a 50 percent interest in the real property held by the LLC. Afterwards, each party separately conveys their fifty percent interest in the property as separate sales to Mike. Juan and Li complete separate REET affidavits for these transactions. As a result of the arrangement, the total real estate excise tax paid on the transactions is $11,000 ((1.1% tax rate x $500,000 selling price) + (1.1% tax rate x $500,000 selling price)).

Result: The department will disregard the reported form of the separate transactions and treat the arrangement as a single sale, with a selling price of $1,000,000. As a result, the proper amount of tax due for the transaction is $11,900. The department will assess $900 in additional real estate excise tax.

Example 7. Tax avoidance - Sale of adjacent real property parcels separately.

Facts: Wei owns two adjacent parcels of real property in Kennewick, a retail shopping plaza and an adjacent parking lot used by patrons of the shopping plaza. Wei advertises the sale of both parcels for a single price of $1,920,000. Wei sells both parcels to Hui on June 15, 2020. Instead of completing a single real estate excise tax affidavit to include both parcels in the reported sale, Wei completes separate affidavits for each parcel, disclosing a selling price of $1,450,000 for the retail shopping plaza and $470,000 for the adjacent parking lot. As a result of the arrangement, the total real estate excise tax paid on the transactions is $22,830 ($17,660 for the retail shopping plaza and $5,170 for the parking lot).

Result: The department will disregard the form of the separate transactions and treat the arrangement as a single sale, with a selling price of $1,920,000. As a result, the proper amount of tax due for the transaction is $29,850. The department will assess $7,020 in additional real estate excise tax.

Example 8. Tax avoidance - Real property sale involving classified and nonclassified land.

Facts: Janice is selling 2 parcels of real property, Parcel A and Parcel B, to Samuel. The selling price is $5,000,000. Parcel A is classified land (agricultural land that is approved by the County Assessor for continued use by Samuel) and Parcel B is nonclassified land. Parcel A is 1,500,000 square

feet. Parcel B is 500,000 square feet. The county assessed value of Parcel A is $900,000. The county assessed value of Parcel B is $3,600,000. The predominant use factors, discussed in subsection (7)(a) of this rule, for Parcels A and B are computed as follows:

• Square footage factor: 0.75 (1,500,000 sq. ft./2,000,000 sq. ft.);

• Value factor: 0.20 ($900,000/$4,500,000).

Adding the two factors and dividing by two yields 0.475 ((0.80 + 0.16)/2). Because this result is less than 0.5, a combined sale of Parcels A and B would be treated as nonclassified land subject to the graduated tax rates.

After determining that the combined sale of Parcels A and B would be subject to graduated tax rates and a total tax liability of $119,550, Janice and Samuel agree to restructure the transaction as two separate sales. Parcel A is sold for $1,000,000 and Parcel B is sold for $4,000,000, resulting in a REET liability of $102,350.

Result: Based on the intent of the parties to restructure the transaction as two separate transactions to avoid tax, the department will disregard the form of the reported sales and treat the sales as a single transaction.

Example 9. Tax avoidance - Real property sale involving classified and nonclassified land.

Facts: Property, Inc. is selling property used as a motor vehicle sales and service center, located in Seattle, WA (Property A). The area of Property A is 130,680 square feet, and its selling price is $23,500,000. Property, Inc. is separately selling a 297 acre parcel (12,937,320 square feet) of agricultural land located in Lincoln County (Property B). The selling price of Property B is $300,000.

Auto Dealer agrees to purchase Property A, which it will use to operate an auto dealership in Seattle. Property, Inc. and Auto Dealer also agree to include Property B in the sale (approved for continued use as classified land by the County Assessor). Auto Dealer is not capable of using the classified land as agricultural land. The agreement between Property, Inc. and Auto Dealer requires Property, Inc. to assist Auto Dealer in reselling Property B and cover certain selling expenses.

At the time of completing the sale, Property, Inc. completes REET affidavits reporting a combined sale of both properties subject to a flat REET rate of 1.28 percent for the entire transaction, and a total liability of $304,640 in state REET. Had Property A and Property B been sold separately, the total REET on the transactions would have been $678,390, a difference of $373,750. Thus, the potential tax savings exceeded the price of including Property B in the sale.

The parties do not provide a substantial nontax reason for arranging the sale of both properties as a single transaction.

Result: The circumstances indicate the transaction was designed to avoid tax. Therefore, the department will disregard the form and treat the transaction as two separate sales.

WSR 21-10-031
PROPOSED RULES
CLOVER PARK TECHNICAL COLLEGE
[Filed April 27, 2021, 10:03 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR [21-06-004].

Title of Rule and Other Identifying Information: Student code of conduct update/revision.

Hearing Location(s): On June 8, 2021, at 10-11 a.m., Zoom https://cptc-edu.zoom.us/j/89554399517.

Date of Intended Adoption: July 15, 2021.

Submit Written Comments to: Dean Kelly, 4500 Steilacoom Boulevard, Lakewood, WA 98499, email dean.kelly@cptc.edu, by May 15, 2021.

Assistance for Persons with Disabilities: Contact Dean Kelly, phone 253-589-6066, email dean.kelly@cptc.edu, by May 15, 2021.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: To adopt new Title IX grievance procedures as mandated by the United States Department of Education (DOE).

Reasons Supporting Proposal: Requirement from United States Department of Education.

Statutory Authority for Adoption: RCW 288.50.140; WSR 14-11-070; United States Department of Education 34 C.F.R. Part 106; chapter 495C-121 WAC.

Statute Being Implemented: Chapter 495C-121 WAC.

Rule is necessary because of federal law, United States Department of Education 34 C.F.R. Part 106.

Name of Proponent: Clover Park Technical College, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: Clover Park Technical College, 4500 Steilacoom Boulevard, Lakewood, WA 98499, 253-589-5800.

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. Just updated language as required by DOE. No fiscal impact.

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. Just updated language in the code of conduct as it relates to adjudicating the process. No fiscal impact or costs.

April 27, 2021
Dean Kelly
Dean of Student Success

AMENDATORY SECTION (Amending WSR 14-11-070, filed 5/19/14, effective 6/19/14)

WAC 495C-121-210 Supplemental sexual misconduct procedures. ((~~In student discipline matters involving allegations of sexual misconduct by a student:~~

~~(1) Both the respondent and the complainant shall be provided the same, or substantially equivalent, procedural~~

~~rights to participate. For the complainant, this includes the rights to meet with the student conduct officer during the initial disciplinary process under WAC 495C-121-100 and to appeal as provided in WAC 495C-121-230.~~

~~(2) These rules shall supplement the foregoing student disciplinary rules in WAC 495C-121-010 through 495C-121-190. In the event of conflict between these supplemental sexual misconduct rules and the foregoing rules, these supplemental rules shall prevail.~~)) Pursuant to RCW 28B.50.140 (13) and Title IX of the Education Amendments Act of 1972, 20 U.S.C. Sec. 1681, Clover Park Technical College may impose disciplinary sanctions against a student who commits, attempts to commit, or aids, abets, incites, encourages, or assists another person to commit, an act(s) of sexual misconduct. The supplemental procedures provided for in WAC 495C-121-210 through 495C-121-270 shall supplement the other procedural requirements of this chapter and will govern all student conduct proceedings regarding alleged acts of sexual misconduct. In the event of a conflict between the supplemental procedure and other requirements of this chapter, the requirements of the supplemental procedure shall control.

For purposes of this supplemental procedure, "sexual misconduct" encompasses the following conduct:

(1) Quid pro quo harassment. A college employee conditioning the provision of an aid, benefit, or service on an individual's participation in unwelcome sexual conduct.

(2) Hostile environment. Unwelcome conduct that a reasonable person would find to be so severe, pervasive, and objectively offensive that it effectively denies a person equal access to Clover Park Technical College's educational programs or activities, or employment.

(3) Sexual assault. Sexual assault includes the following conduct:

(a) Nonconsensual sexual intercourse. Any actual or attempted sexual intercourse (anal, oral, or vaginal), however slight, with any object or body part, by a person upon another person, that is without consent and/or by force. Sexual intercourse includes anal or vaginal penetration by a penis, tongue, finger, or object, or oral copulation by mouth to genital contact or genital to mouth contact.

(b) Nonconsensual sexual contact. Any actual or attempted sexual touching, however slight, with any body part or object, by a person upon another person that is without consent and/or by force. Sexual touching includes any bodily contact with the breasts, groin, mouth, or other bodily orifice of another individual, or any other bodily contact in a sexual manner.

(c) Incest. Sexual intercourse or sexual contact with a person known to be related to them, either legitimately or illegitimately, as an ancestor, descendant, brother, or sister of either wholly or half related. Descendant includes stepchildren and adopted children under the age of eighteen.

(d) Statutory rape. Consensual sexual intercourse between someone who is eighteen years of age or older and someone who is under the age of sixteen.

(4) Domestic violence. Physical violence, bodily injury, assault, the infliction of fear of imminent physical harm, sexual assault, or stalking committed by a person with whom the victim shares a child in common, by a person who is cohabitating with or has cohabitated with the victim as a spouse, by a person similarly situated to a spouse of the victim under the domestic or family violence laws of the state of Washington, or by any other person against an adult or youth victim who is protected from that person's acts under the domestic or family violence laws of the state of Washington, RCW 26.50.010.

(5) Dating violence. Physical violence, bodily injury, assault, the infliction of fear of imminent physical harm, sexual assault, or stalking committed by a person:

(a) Who is or has been in a social relationship of a romantic or intimate nature with the victim; and

(b) Where the existence of such a relationship shall be determined based on a consideration of the following factors:

(i) The length of the relationship;

(ii) The type of relationship; and

(iii) The frequency of interaction between the persons involved in the relationship.

(6) Stalking. Engaging in a course of conduct directed at a specific person that would cause a reasonable person to fear for their safety or the safety of others or suffer substantial emotional distress.

NEW SECTION

WAC 495C-121-215 Title IX jurisdiction. (1) This supplemental procedure applies only if the alleged misconduct:

(a) Occurred in the United States;

(b) Occurred during a Clover Park Technical College educational program or activity; and

(c) Meets the definition of sexual harassment as that term is defined in this supplemental procedure.

(2) For purposes of this supplemental procedure, an "educational program or activity" is defined as locations, events, or circumstances over which Clover Park Technical College exercised substantial control over both the respondent and the context in which the alleged sexual harassment occurred. This definition includes any building owned or controlled by a student organization that is officially recognized by the college.

(3) Proceedings under this supplemental procedure must be dismissed if the decision maker determines that one or all of the requirements of subsection (1)(a) through (c) of this section, have not been met. Dismissal under this Title IX supplemental procedure does not prohibit the college from pursuing other disciplinary action based on in situations where the allegations against the respondent, if true, would constitute violations of other provisions of the college's student conduct code, chapter 495C-121 WAC.

(4) If the student conduct officer determines the facts in the investigation report are not sufficient to support Title IX jurisdiction and/or pursuit of a Title IX violation, the student conduct officer will issue a notice of dismissal in whole or part to both parties explaining why some or all of the Title IX claims have been dismissed.

AMENDATORY SECTION (Amending WSR 14-11-070, filed 5/19/14, effective 6/19/14)

WAC 495C-121-220 Supplemental complaint process. With respect to complaints or other reports of alleged sexual misconduct by a student:

(1) The college's Title IX compliance officer shall investigate, or assure investigation of, complaints or other reports of alleged sexual misconduct by a student. The investigation will be completed in a timely manner and the results of the investigation shall be referred to the student conduct officer for possible disciplinary action.

(2) Informal dispute resolution shall not be used to resolve sexual misconduct complaints without written permission from both the complainant and the respondent. If the parties elect to mediate a dispute, either party shall be free to discontinue the mediation at any time. Mediation shall not be used to resolve complaints involving allegations of sexual violence.

(3) College personnel will honor requests to keep sexual misconduct complaints confidential to the extent this can be done without unreasonably risking the health, safety, and welfare of the complainant or other members of the college community or compromising the college's duty to investigate and process such complaints.

(((~~(4) The student conduct officer, prior to serving a disciplinary decision under WAC 495C-121-100, will make a reasonable effort to contact the complainant to discuss the results of the investigation and possible disciplinary sanctions and/or disciplinary conditions that may be imposed.~~

~~(5) The student conduct officer, on the same date that a disciplinary decision is served on the respondent under WAC 495C-121-100, will serve a written notice, in compliance with FERPA, informing the complainant whether the allegations of sexual misconduct were found to have merit and describing any disciplinary sanctions and/or conditions which are being imposed upon the respondent for the complainant's protection. The notice will also inform the complainant of her/his rights to appeal as stated in WAC 495C-121-230. If protective disciplinary sanctions and/or conditions are imposed, the student conduct officer shall also make a reasonable effort to have the notice served upon the complainant prior to service upon the respondent.~~))

NEW SECTION

WAC 495C-121-225 Initiation of discipline. (1) Upon receiving the Title IX investigation report from the Title IX compliance officer, the student conduct officer will independently review the report to determine whether there are sufficient grounds to pursue a disciplinary action against the respondent for engaging in prohibited conduct under Title IX.

(2) If the student conduct officer determines that there are sufficient grounds to proceed under these supplemental procedures, the student conduct officer will initiate a Title IX disciplinary proceeding by filing a written disciplinary notice with the chair of the student conduct committee and serving the notice on the respondent and the complainant, and their respective advisors. The notice must:

(a) Set forth the basis for Title IX jurisdiction;

(b) Identify the alleged Title IX violation(s);

(c) Set forth the facts underlying the allegation(s);

(d) Identify the range of possible sanctions that may be imposed if the respondent is found responsible for the alleged violation(s);

(e) Explain that the parties are entitled to be accompanied by their chosen advisors during the hearing and that:

(i) The advisors will be responsible for questioning all witnesses on the party's behalf;

(ii) An advisor may be an attorney; and

(iii) The college will appoint the party an advisor of the college's choosing at no cost to the party, if the party fails to do so.

(3) Explain that if a party fails to appear at the hearing, a decision of responsibility may be made in their absence.

NEW SECTION

WAC 495C-121-235 Prehearing procedure. (1) Upon receiving the disciplinary notice, the chair of the student conduct committee will send a hearing notice to all parties, in compliance with WAC 495C-121-150. In no event will the hearing date be set less than ten days after the Title IX compliance officer provides the final investigation report to the parties.

(2) A party may choose to have an attorney serve as their advisor at the party's own expense. This right will be waived unless, at least five days before the hearing, the attorney files a notice of appearance with the committee chair with copies to all parties and the student conduct officer.

(3) In preparation for the hearing, the parties will have equal access to all evidence gathered by the investigator during the investigation, regardless of whether the college intends to offer the evidence at the hearing.

NEW SECTION

WAC 495C-121-240 Rights of parties. (1) Clover Park Technical College's student conduct procedures, chapter 495C-121 WAC, and this supplemental procedure shall apply equally to all parties.

(2) The college bears the burden of offering and presenting sufficient testimony and evidence to establish that the respondent is responsible for a Title IX violation by a preponderance of the evidence.

(3) The respondent will be presumed not responsible until such time as the disciplinary process has been finally resolved.

(4) During the hearing, each party shall be represented by an advisor. The parties are entitled to an advisor of their own choosing and the advisor may be an attorney. If a party does not choose an advisor, then the Title IX compliance officer will appoint an advisor of the college's choosing on the party's behalf at no expense to the party.

NEW SECTION

WAC 495C-121-250 Evidence. The introduction and consideration of evidence during the hearing is subject to the following procedures and restrictions:

(1) Relevance: The chair of the student conduct committee shall review all questions for relevance and shall explain

on the record their reasons for excluding any question based on lack of relevance.

(2) Relevance means that information elicited by the question makes facts in dispute more or less likely to be true.

(3) Questions or evidence about a complainant's sexual predisposition or prior sexual behavior are not relevant and must be excluded, unless such question or evidence:

(a) Is asked or offered to prove someone other than the respondent committed the alleged misconduct; or

(b) Concerns specific incidents of prior sexual behavior between the complainant and the respondent, which are asked or offered on the issue of consent.

(4) Cross-examination required: If a party or witness does not submit to cross-examination during the live hearing, the committee must not rely on any statement by that party or witness in reaching a determination of responsibility.

(5) No negative inference: The committee may not make an inference regarding responsibility solely on a witness's or party's absence from the hearing or refusal to answer questions.

(6) Privileged evidence: The committee shall not consider legally privileged information unless the holder has effectively waived the privilege. Privileged information includes, but is not limited to, information protected by the following:

(a) Spousal/domestic partner privilege;

(b) Attorney-client and attorney work product privileges;

(c) Privileges applicable to members of the clergy and priests;

(d) Privileges applicable to medical providers, mental health therapists, and counselors;

(e) Privileges applicable to sexual assault and domestic violence advocates; and

(f) Other legal privileges identified in RCW 5.60.060.

NEW SECTION

WAC 495C-121-260 Initial order. (1) In addition to complying with chapter 495C-121 WAC, the student conduct committee will be responsible for conferring and drafting an initial order that:

(a) Identifies the allegations of sexual harassment;

(b) Describes the grievance and disciplinary procedures, starting with filing of the formal complaint through the determination of responsibility, including notices to parties, interviews with witnesses and parties, site visits, methods used to gather evidence, and hearings held;

(c) Makes findings of fact supporting the determination of responsibility;

(d) Reaches conclusions as to whether the facts establish whether the respondent is responsible for engaging in sexual harassment in violation of Title IX;

(e) Contains a statement of, and rationale for, the committee's determination of responsibility for each allegation;

(f) Describes any disciplinary sanction or conditions imposed against the respondent, if any;

(g) Describes to what extent, if any, complainant is entitled to remedies designed to restore or preserve complainant's equal access to Clover Park Technical College's educational programs or activities; and

(h) Describes the process for appealing the initial order to the college president.

(2) The chair of the student conduct committee will serve the initial order on the parties simultaneously.

NEW SECTION

WAC 495C-121-270 Appeals. (1) The parties shall have the right to appeal from the initial order's determination of responsibility and/or dismissal of an allegation(s) of sexual harassment in a formal complaint. The right to appeal will be subject to the same procedures and time frames set forth in WAC 495C-121-080.

(2) The president or designee will determine whether the grounds for appeal have merit, provide the rationale for this conclusion, and state whether the disciplinary sanction and condition(s) imposed in the initial order are affirmed, vacated, or amended, and, if amended, set forth any new disciplinary sanction and/or condition(s).

(3) President's office shall serve the final decision on the parties simultaneously.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 495C-121-230 Supplemental appeal rights.

WSR 21-10-040
PROPOSED RULES
LIQUOR AND CANNABIS BOARD

[Filed April 28, 2021, 1:07 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 20-01-171.

Title of Rule and Other Identifying Information: WAC 314-55-075 Marijuana producer license—Privileges, requirements and fees. The Washington state liquor and cannabis board (board) is proposing rule amendments to expand the plant canopy square footage allowed for licensed Tier 1 marijuana (cannabis) producers.

Hearing Location(s): On June 9, 2021, at 10:00 a.m. In response to the coronavirus disease 2019 (COVID-19) public health emergency, the board 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. Board members, presenters, and staff will all participate remotely. The public may login using a computer or device, or call-in using a phone, to listen to the meeting through the WebEx application. The public may provide verbal comments during the specified public comment and rules hearing segments. For more information about board meetings, please visit https://lcb.wa.gov/boardmeetings/ board_-meetings.

Date of Intended Adoption: Not earlier than June 16, 2021.

Submit Written Comments to: Policy and Rules Coordinator, 1025 Union Avenue S.E., Olympia, WA 98504, email rules@lcb.wa.gov, by June 9, 2021.

Assistance for Persons with Disabilities: Contact Claris Nhanabu, ADA coordinator, human resources, phone 360-664-1642, fax 360-664-9689, TTY 711 or 1-800-833-6388, email Claris.Nhanabu@lcb.wa.gov, by June 2, 2021.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Currently, Tier 1 cannabis producer licensees are limited to two thousand square feet of production canopy. Some of these Tier 1 businesses find it difficult to operate a successful business under the current square footage limit. The proposed rules would expand current Tier 1 canopy from two thousand to four thousand square feet of production canopy. It would also align the Tier 2 canopy from two thousand square feet up to ten thousand square feet to four thousand square feet to ten thousand square feet of production canopy.

Reasons Supporting Proposal: Tier 1 licensees experience business sustainability and viability challenges based on canopy space restrictions. Following two stakeholder engagement sessions, the agency conducted a follow up targeted survey of Tier 1 licensees. One of the most common responses was a request to expand canopy to allow Tier 1 licensees to be competitive in the current market. As of 2019, Tier 1 licensed canopy represents the fewest cannabis production licenses (less than two hundred) and the smallest amount of overall canopy—approximately three hundred fifty thousand square feet, or 1.9 percent of the eighteen million forty thousand square feet of licensed canopy in Washington state. The option to expand growth capacity will add value to the Tier 1 producer license type, support business viability and sustainability, and create an opportunity for Tier 1 producer licensees to become more competitve [competitive] in the competitive Washington state cannabis market.

Statutory Authority for Adoption: RCW 69.50.342, 69.50.345.

Statute Being Implemented: RCW 69.50.345.

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: Not applicable.

Name of Proponent: Washington state liquor and cannabis board (WSLCB), governmental.

Name of Agency Personnel Responsible for Drafting: Policy and Rules Coordinator, 1025 Union Avenue S.E., Olympia, WA 98502, 360-664-1760; Implementation: Becky Smith, Director of Licensing, 1025 Union Avenue S.E., Olympia, WA 98502, 360-664-1753; and Enforcement: Chandra Brady, Director of Education and Enforcement, 1025 Union Avenue S.E., Olympia, WA 98502, 360-664-1726.

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 Policy and Rules Coordinator, 1025 Union Avenue S.E., Olympia, WA 98502, phone 360-664-1622.

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 rule does not impose any additional mandatory regulatory burden on applicants or licensees, nor does it change, modify, add cost or otherwise alter the license application process. The option to expand Tier 1 growing capacity is voluntary, and not required.

However, to make that determination, WSLCB applied a default cost of compliance ($300) when analyzing whether the rules would have a disproportionate impact on small businesses as defined in RCW 19.85.020(3). This represents the following:

- A $75 fee for an alteration request application;
- $75 for one and [one] half hours of licensee time to complete forms and communicate with WSLCB regarding expansion;
- $50 for one hour of licensee time to be present for final inspection;
- $100 for two hours of work to expand security and video system; and
- Estimated total: $300.

Below are calculations for minor cost thresholds for the appropriate NAICS industry codes. While these estimates are largely based on broad application, rather than the three-tiered system in Washington state, even if scaled, it is unlikely that the cost of compliance would exceed 0.3 percent of average annual gross business income. The estimated minor cost is not anticipated to exceed any of the thresholds for cannabis grown under cover or in an open field. Since this rule provides an *option* to expand capacity to one tier with the smallest number of licensees, and that expansion is not required to remain in compliance, these costs are not mandated but optional. Other costs incurred are also voluntary, such as expanding fence lines and working with local authorities. For these reasons, the proposed rules are not anticipated to impose more-than-minor costs on businesses as defined by RCW 19.85.020(2).

2017 Industry NAICS Code	Estimated Cost of Compliance	Industry Description	NAICS Code Title	Minor Cost Estimate	1% of Avg Annual Payroll	0.3% of Avg Annual Gross Business Income
111419	$300	Cannabis, grown under cover	Other Food Crops Grown Under Cover	$2,349.42	$2,349.42 2018 Dataset pulled from ESD	$2,324.68 2018 Dataset pulled from DOR

2017 Industry NAICS Code	Estimated Cost of Compliance	Industry Description	NAICS Code Title	Minor Cost Estimate	1% of Avg Annual Payroll	0.3% of Avg Annual Gross Business Income
111998	$300	Cannabis, grown in an open field	All Other Miscellaneous Crop Farming	$9,125.33	$9,125.33 2018 Dataset pulled from ESD	$2,834.77 2018 Dataset pulled from DOR

April 28, 2021
David Postman
Board Chair

AMENDATORY SECTION (Amending WSR 18-22-055, filed 10/31/18, effective 12/1/18)

WAC 314-55-075 Marijuana producer license—Privileges, requirements, and fees. (1)(a) A marijuana producer license allows the licensee to produce, harvest, trim, dry, cure, and package marijuana into lots for sale at wholesale to marijuana processor licensees and to other marijuana producer licensees. A marijuana producer may also produce and sell:

(i) Marijuana plants, seed, and plant tissue culture to other marijuana producer licensees;

(ii) Immature marijuana plants or clones and marijuana seeds to members of a registered cooperative, qualifying patients, or designated providers under the conditions provided in this chapter; and

(iii) Immature marijuana plants or clones and marijuana seeds to a licensed marijuana researcher under the conditions provided in this chapter.

(b) Marijuana production must take place within a fully enclosed secure indoor facility or greenhouse with rigid walls, a roof, and doors. Outdoor production may take place in nonrigid greenhouses, other structures, or an expanse of open or cleared ground fully enclosed by a physical barrier. To obscure public view of the premises, outdoor production must be enclosed by a sight obscure wall or fence at least eight feet high. Outdoor producers must meet security requirements described in WAC 314-55-083. An outdoor grow must be physically separated at least twenty feet from another licensed outdoor grow. In addition, outdoor grows cannot share common walls or fences.

(2) The application fee for a marijuana producer license is two hundred fifty dollars. The applicant is also responsible for paying the fees required by the approved vendor for fingerprint evaluation.

(3) The annual fee for issuance and renewal of a marijuana producer license is one thousand dollars. The annual fee for issuance and renewal of a marijuana producer license is one thousand three hundred eighty-one dollars. The WSLCB will conduct random criminal history checks at the time of renewal that will require the licensee to submit fingerprints for evaluation from the approved vendor. The licensee is responsible for all fees required for criminal history checks.

(4) The application window for marijuana producer licenses is closed. The WSLCB may reopen the marijuana producer application window at subsequent times when the WSLCB deems necessary.

(5) Any entity and/or principals within any entity are limited to an interest, as defined in WAC 314-55-035, in no more than three marijuana producer licenses.

(6) The maximum amount of space for marijuana production cannot exceed the amount licensed. Applicants must designate on their operating plan the size category of the production premises and the amount of actual square footage in their premises that will be designated as plant canopy. There are three categories as follows:

(a) Tier 1 - Less than ((~~two~~)) four thousand square feet;

(b) Tier 2 - ((~~Two~~)) Four thousand square feet up to ten thousand square feet; and

(c) Tier 3 - Ten thousand square feet up to thirty thousand square feet.

(7) The WSLCB may reduce a licensee's or applicant's square footage designated to plant canopy for the following reasons:

(a) If the amount of square feet of production of all licensees exceeds the maximum square feet the WSLCB will reduce the allowed square footage by the same percentage.

(b) If fifty percent production space used for plant canopy in the licensee's operating plan is not met by the end of the first year of operation the WSLCB may reduce the tier of licensure.

(8) If the total amount of square feet of marijuana production exceeds the maximum square feet, the WSLCB reserves the right to reduce all licensee's production by the same percentage or reduce licensee production by one or more tiers by the same percentage.

(9) The maximum allowed amount of marijuana on a producer's premises at any time is as follows:

(a) Outdoor or greenhouse grows - One and one-quarter of a year's harvest; or

(b) Indoor grows - Six months of their annual harvest.

(10) A producer may not treat or otherwise adulterate useable marijuana with any organic or nonorganic chemical or other compound whatsoever to alter the color, appearance, weight, or smell of the useable marijuana.

(11) A marijuana producer must make quality assurance test results available to any processor purchasing product. A marijuana producer must label each lot of marijuana with the following information:

(a) Lot number;

(b) UBI number of the producer; and

(c) Weight of the product.

WSR 21-10-042
PROPOSED RULES
DEPARTMENT OF REVENUE
[Filed April 28, 2021, 1:16 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 21-03-091.

Title of Rule and Other Identifying Information: WAC 458-40-660 Timber excise tax—Stumpage value tables—Stumpage value adjustments.

Hearing Location(s): On June 8, 2021, at 11:30 a.m. This meeting will be conducted over the internet and telephone. Contact Keith Dacus, management analyst, at KeithD@dor.wa.gov for login/dial-in information.

Date of Intended Adoption: June 16, 2020.

Submit Written Comments to: Jennifer Arnold, P.O. Box 47453, Olympia, WA 98504-7453, email JenniferA@dor.wa.gov, fax 360-534-1606, by June 11, 2021.

Assistance for Persons with Disabilities: Contact Julie King or Renee Cosare, phone 360-704-5733 or 360-704-5734, TTY 800-833-6384.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: RCW 84.33.091 requires the department to revise the stumpage value tables every six months. The department establishes the stumpage value tables to apprise timber harvesters of the timber values used to calculate the timber excise tax. The values in the proposed rule will apply July 1 through December 31, 2020 [2021].

Reasons Supporting Proposal: This proposal provides the revised stumpage value tables for July 1 through December 31, 2021.

Statutory Authority for Adoption: RCW 82.01.060(2), 84.33.096, 82.32.300.

Statute Being Implemented: RCW 84.33.091.

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

Name of Proponent: Department of revenue, governmental.

Name of Agency Personnel Responsible for Drafting: Jennifer Arnold, 6400 Linderson Way S.W., Tumwater, WA, 360-534-1583; Implementation and Enforcement: John Ryser, 6400 Linderson Way S.W., Tumwater, WA, 360-534-1605.

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 Jennifer Arnold, Interpretations and Technical Advice Division, P.O. Box 47453, Olympia, WA 98504-7453, phone 360-534-1574, fax 360-534-1606.

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 does not impose more-than-minor costs on businesses, as it does not propose any new requirements.

April 28, 2021
Atif Aziz
Rules Coordinator

AMENDATORY SECTION (Amending WSR 21-02-020, filed 12/28/20, effective 1/1/21)

WAC 458-40-660 Timber excise tax—Stumpage value tables—Stumpage value adjustments. (1) **Introduction.** This rule provides stumpage value tables and stumpage value adjustments used to calculate the amount of a harvester's timber excise tax.

(2) **Stumpage value tables.** The following stumpage value tables are used to calculate the taxable value of stumpage harvested from ((~~January 1st~~)) July 1 through ((~~June 30~~)) December 31, 2021:

Washington State Department of Revenue
WESTERN WASHINGTON STUMPAGE VALUE TABLE
((~~January~~)) July 1 through ((~~June 30~~)) December 31, 2021
Stumpage Values per Thousand Board Feet Net Scribner Log Scale(1)
Starting January 1, 2019, there are no Haul Zone adjustments.

Species Name	Species Code	SVA (Stumpage Value Area)	Stumpage Values
Douglas-fir(2)	DF	1	((~~$391~~)) 422
		2	((~~453~~)) 520
		3	((~~483~~)) 520
		4	((~~511~~)) 573
		5	((~~465~~)) 539
		9	((~~377~~)) 408
Western Hemlock and Other Conifer(3)	WH	1	((~~226~~)) 282
		2	((~~290~~)) 395
		3	((~~389~~)) 419
		4	((~~320~~)) 348
		5	((~~255~~)) 362
		9	((~~212~~)) 268
Western Redcedar(4)	RC	1-5	((~~932~~)) 1153
		9	((~~918~~)) 1139
Ponderosa Pine(5)	PP	1-5	((~~158~~)) 163
		9	((~~144~~)) 149

Species Name	Species Code	SVA (Stumpage Value Area)	Stumpage Values
Red Alder	RA	1-5	((~~343~~)) 363
		9	((~~329~~)) 349
Black Cottonwood	BC	1-5	((~~1~~)) 19
		9	((~~1~~)) 5
Other Hardwood	OH	1-5	((~~159~~)) 123
		9	((~~145~~)) 109
Douglas-fir Poles & Piles	DFL	1-5	((~~798~~)) 811
		9	((~~784~~)) 797
Western Redcedar Poles	RCL	1-5	((~~1459~~)) 1724
		9	((~~1445~~)) 1710
Chipwood[6]	CHW	1-5	((~~5~~)) 1
		9	((~~3~~)) 1
RC Shake & Shingle Blocks[7]	RCS	1-9	301
Posts[8]	LPP	1-9	0.35
DF Christmas Trees[9]	DFX	1-9	0.25
Other Christmas Trees[9]	TFX	1-9	0.50

(1) Log scale conversions Western and Eastern Washington. See conversion methods WAC 458-40-680.

(2) Includes Western Larch.

(3) Includes all Hemlock, Spruce and true Fir species, or any other conifer not listed on this page.

(4) Includes Alaska-Cedar.

(5) Includes all Pines in SVA 1-5 & 9.

(6) Stumpage value per ton.

(7) Stumpage value per cord.

(8) Includes Lodgepole posts and other posts, Stumpage value per 8 lineal feet or portion thereof.

(9) Stumpage value per lineal foot.

Washington State Department of Revenue
EASTERN WASHINGTON STUMPAGE VALUE TABLE
((~~January~~)) July 1 through ((~~June 30~~)) December 31, 2021
Stumpage Values per Thousand Board Feet Net Scribner Log Scale[1]
Starting January 1, 2019, there are no Haul Zone adjustments.

Species Name	Species Code	SVA (Stumpage Value Area)	Stumpage Values
Douglas-fir[2]	DF	6	$((~~233~~)) 299
		7	((~~247~~)) 313
Western Hemlock and Other Conifer[3]	WH	6	((~~204~~)) 231
		7	((~~218~~)) 245
Western Redcedar[4]	RC	6	((~~704~~)) 945
		7	((~~718~~)) 959
Ponderosa Pine[5]	PP	6	((~~144~~)) 149
		7	((~~158~~)) 163
Other Hardwood	OH	6	((~~4~~)) 1
		7	((~~18~~)) 9
Western Redcedar Poles	RCL	6	((~~1442~~)) 1594
		7	((~~1456~~)) 1608
Chipwood[6]	CHW	6	1
		7	((~~2~~)) 1
Small Logs[6]	SML	6	((~~16~~)) 20
		7	((~~18~~)) 22
RC Shake & Shingle Blocks[7]	RCS	6-7	301
Posts[8]	LPP	6-7	0.35
DF Christmas Trees[9]	DFX	6-7	0.25
Other Christmas Trees[9]	TFX	6-7	0.50

(1) Log scale conversions Western and Eastern Washington. See conversion methods WAC 458-40-680.

(2) Includes Western Larch.

(3) Includes all Hemlock, Spruce and true Fir species, and Lodgepole Pine in SVA 6-7, or any other conifer not listed on this table.

(4) Includes Alaska-Cedar.

(5) Includes Western White Pine in SVA 6-7.

(6) Stumpage value per ton.

(7) Stumpage value per cord.

(8) Includes Lodgepole posts and other posts, Stumpage value per 8 lineal feet or portion thereof.

(9) Stumpage value per lineal foot.

(3) **Harvest value adjustments.** The stumpage values in subsection (2) of this rule for the designated stumpage value areas are adjusted for various logging and harvest conditions, subject to the following:

(a) No harvest adjustment is allowed for special forest products, chipwood, or small logs.

(b) Conifer and hardwood stumpage value rates cannot be adjusted below one dollar per MBF.

(c) Except for the timber yarded by helicopter, a single logging condition adjustment applies to the entire harvest unit. The taxpayer must use the logging condition adjustment class that applies to a majority (more than 50%) of the acreage in that harvest unit. If the harvest unit is reported over more than one quarter, all quarterly returns for that harvest unit must report the same logging condition adjustment. The helicopter adjustment applies only to the timber volume from the harvest unit that is yarded from stump to landing by helicopter.

(d) The volume per acre adjustment is a single adjustment class for all quarterly returns reporting a harvest unit. A harvest unit is established by the harvester prior to harvesting. The volume per acre is determined by taking the volume logged from the unit excluding the volume reported as chipwood or small logs and dividing by the total acres logged. Total acres logged does not include leave tree areas (RMZ, UMZ, forested wetlands, etc.,) over 2 acres in size.

(e) A domestic market adjustment applies to timber which meet the following criteria:

(i) **Public timber** - Harvest of timber not sold by a competitive bidding process that is prohibited under the authority of state or federal law from foreign export may be eligible for the domestic market adjustment. The adjustment may be applied only to those species of timber that must be processed domestically. According to type of sale, the adjustment may be applied to the following species:

Federal Timber Sales: All species except Alaska-cedar. (Stat. Ref. - 36 C.F.R. 223.10)

State, and Other Nonfederal, Public Timber Sales: Western Redcedar only. (Stat. Ref. - 50 U.S.C. appendix 2406.1)

(ii) **Private timber** - Harvest of private timber that is legally restricted from foreign export, under the authority of The Forest Resources Conservation and Shortage Relief Act (Public Law 101-382), (16 U.S.C. Sec. 620 et seq.); the Export Administration Act of 1979 (50 U.S.C. App. 2406(i)); a Cooperative Sustained Yield Unit Agreement made pursuant to the act of March 29, 1944 (16 U.S.C. Sec. 583-583i); or Washington Administrative Code (WAC 240-15-015(2)) is also eligible for the Domestic Market Adjustment.

The following harvest adjustment tables apply from ((~~January 1st~~)) July 1 through ((~~June 30~~)) December 31, 2021:

TABLE 9—Harvest Adjustment Table
Stumpage Value Areas 1, 2, 3, 4, 5, and 9
((~~January~~)) July 1 through ((~~June 30~~)) December 31, 2021

Type of Adjustment	Definition	Dollar Adjustment Per Thousand Board Feet Net Scribner Scale
I. Volume per acre		
Class 1	Harvest of 30 thousand board feet or more per acre.	$0.00
Class 2	Harvest of 10 thousand board feet to but not including 30 thousand board feet per acre.	-$15.00
Class 3	Harvest of less than 10 thousand board feet per acre.	-$35.00
II. Logging conditions		
Class 1	Ground based logging a majority of the unit using tracked or wheeled equipment or draft animals.	$0.00
Class 2	Logging a majority of the unit: Using an overhead system of winch-driven cables and/or logging on slopes greater than 45% using tracked or wheeled equipment supported by winch-driven cables.	-$85.00
Class 3	Applies to logs yarded from stump to landing by helicopter. This does not apply to special forest products.	-$200.00
III. Remote island adjustment:		
	For timber harvested from a remote island	-$50.00
IV. Thinning		
Class 1	A limited removal of timber described in WAC 458-40-610 (28)	-$100.00

TABLE 10—Harvest Adjustment Table
Stumpage Value Areas 6 and 7
((~~January~~)) July 1 through ((~~June 30~~)) December 31, 2021

Type of Adjustment	Definition	Dollar Adjustment Per Thousand Board Feet Net Scribner Scale
I. Volume per acre		
Class 1	Harvest of more than 8 thousand board feet per acre.	$0.00
Class 2	Harvest of 8 thousand board feet per acre and less.	-$8.00
II. Logging conditions		
Class 1	The majority of the harvest unit has less than 40% slope. No significant rock outcrops or swamp barriers.	$0.00
Class 2	The majority of the harvest unit has slopes between 40% and 60%. Some rock outcrops or swamp barriers.	-$50.00

Type of Adjustment	Definition	Dollar Adjustment Per Thousand Board Feet Net Scribner Scale
Class 3	The majority of the harvest unit has rough, broken ground with slopes over 60%. Numerous rock outcrops and bluffs.	-$85.00
Class 4	Applies to logs yarded from stump to landing by helicopter. This does not apply to special forest products.	-$200.00

Note: A Class 2 adjustment may be used for slopes less than 40% when cable logging is required by a duly promulgated forest practice regulation. Written documentation of this requirement must be provided by the taxpayer to the department of revenue.

III. Remote island adjustment:

For timber harvested from a remote island	-$50.00

TABLE 11—Domestic Market Adjustment

Class	Area Adjustment Applies	Dollar Adjustment Per Thousand Board Feet Net Scribner Scale
	SVAs 1 through 5 only:	$0.00

Note: This adjustment only applies to published MBF sawlog values.

(4) **Damaged timber.** Timber harvesters planning to remove timber from areas having damaged timber may apply to the department of revenue for an adjustment in stumpage values. The application must contain a map with the legal descriptions of the area, an accurate estimate of the volume of damaged timber to be removed, a description of the damage sustained by the timber with an evaluation of the extent to which the stumpage values have been materially reduced from the values shown in the applicable tables, and a list of estimated additional costs to be incurred resulting from the removal of the damaged timber. The application must be received and approved by the department of revenue before the harvest commences. Upon receipt of an application, the department of revenue will determine the amount of adjustment to be applied against the stumpage values. Timber that has been damaged due to sudden and unforeseen causes may qualify.

(a) Sudden and unforeseen causes of damage that qualify for consideration of an adjustment include:

(i) Causes listed in RCW 84.33.091; fire, blow down, ice storm, flood.

(ii) Others not listed; volcanic activity, earthquake.

(b) Causes that do not qualify for adjustment include:

(i) Animal damage, root rot, mistletoe, prior logging, insect damage, normal decay from fungi, and pathogen caused diseases; and

(ii) Any damage that can be accounted for in the accepted normal scaling rules through volume or grade reductions.

(c) The department of revenue will not grant adjustments for applications involving timber that has already been harvested but will consider any remaining undisturbed damaged timber scheduled for removal if it is properly identified.

(d) The department of revenue will notify the harvester in writing of approval or denial. Instructions will be included for taking any adjustment amounts approved.

(5) **Forest-derived biomass,** has a $0/ton stumpage value.

WSR 21-10-055
PROPOSED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Economic Services Administration)

[Filed April 29, 2021, 12:47 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 20-22-079 and 21-03-009.

Title of Rule and Other Identifying Information: The department is proposing adoption of WAC 388-437-0015 Good cause extension of Social Security number (SSN) requirement for basic food applicants during COVID-19; and amendments to WAC 388-476-0005 Social Security number requirements.

Hearing Location(s): On June 8, 2021, at 10:00 a.m., at Office Building 2, Department of Social and Health (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 June 9, 2021.

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., June 8, 2021.

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 May 25, 2021.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: These proposed rule changes allow good cause for failure to provide an SSN to continue during the COVID[-19] emergency, contingent upon ongoing federal approval, and clarify timeframes for showing good cause in accordance with federal regulations.

Reasons Supporting Proposal: During the COVID[-19] public health crisis, DSHS has received waivers each month since March 2020 from the United States Department of Agriculture's Food and Nutrition Service, allowing the department to grant good cause to those unable to obtain an SSN. This proposal aligns rule language regarding good cause with the applicable section of the Code of Federal Regulations, 7 C.F.R. 273.6(d).

Statutory Authority for Adoption: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090.

Rule is necessary because of federal law, 7 C.F.R. 273.6 (d).

Name of Proponent: DSHS, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: Carolyn Horlor, P.O. Box 45470, Olympia, WA 98504-5470, 360-764-0676.

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."

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

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

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

April 28, 2021
Katherine I. Vasquez
Rules Coordinator

NEW SECTION

WAC 388-437-0015 Good cause extension of Social Security number (SSN) requirement for basic food applicants during COVID-19. Applicants for food benefits must provide an SSN under WAC 388-476-0005(1) to qualify. For those who do not have an SSN, they must apply for one and provide it to DSHS when issued.

(1) For applicants with an initial application date of March 1, 2020, or later, who have established good cause for failure to provide an SSN, the good cause period is extended for three months, in addition to the application month and the next month under WAC 388-476-0005 (5)(a), for a total of up to five months.

(2) To continue receiving benefits beyond the five month good cause period, the applicant must show good cause for failure to apply for an SSN on a monthly basis in accordance with WAC 388-476-0005 (5)(b).

(3) Adjustments under subsection (1) of this section will continue each month until the U.S. Department of Agriculture, Food and Nutrition Service no longer approves these adjustments.

AMENDATORY SECTION (Amending WSR 13-18-005, filed 8/22/13, effective 10/1/13)

WAC 388-476-0005 Social Security number requirements. (1) With certain exceptions, each person who applies for or receives cash or food assistance benefits must provide to the department a Social Security number (SSN), or numbers if more than one has been issued. For SSN requirements for immigrants, see WAC 388-424-0009.

(2) If the person is unable to provide the SSN, either because it is not known or has not been issued, the person must:

(a) Apply for the SSN;

(b) Provide proof that the SSN has been applied for; and

(c) Provide the SSN when it is received.

(3) Assistance will not be delayed, denied or terminated pending the issuance of an SSN by the Social Security Administration. However, a person who does not comply with these requirements is not eligible for assistance.

(4) For cash and food assistance benefits, a person cannot be disqualified from receiving benefits for refusing to apply for or supply an SSN based on religious grounds.

(5) For food assistance programs:

(a) A person can receive benefits for the month of application and the following month if the person attempted to apply for the SSN and made every effort to provide the needed information to the Social Security Administration.

(b) For a person to receive benefits after the time period provided in subsection (5)(a) of this section, good cause for failure to apply for the SSN must be shown monthly.

(c) If a person is unable to provide proof of application for a SSN for a newborn:

(i) The newborn can receive basic food with the household ((~~while effort is being made~~)) makes efforts to get the SSN.

(ii) For the newborn to continue receiving basic food benefits; the household must provide proof of application for SSN or the SSN for the newborn, at the next recertification, or within six months following the month the baby is born, whichever is later.

(6) ((~~There is~~)) No SSN ((~~requirement~~)) is required for the following programs:

(a) The consolidated emergency assistance program; and

(b) The refugee cash assistance program.

WSR 21-10-056
WITHDRAWAL OF PROPOSED RULES
CLARK COLLEGE
[Filed April 29, 2021, 2:31 p.m.]

Clark College (the college) is withdrawing CR-102 Proposed rule making for chapters 132N-125, 132N-126, and 132N-300 WAC, published by the code reviser in WSR 21-08-034 and scheduled for a virtual public hearing on May 26, 2021.

The college's proposed rule change needs to be amended to incorporate new model language issued by the state's attorney general's office on April 19, 2021.

The college plans to refile the proposed rule[s], though a date has not yet been identified.

Please contact Bob Williamson at bwilliamson@clark.edu or at 360-823-3425 if you have any questions.

Bob Williamson
Special Projects Administrator

WSR 21-10-061
PROPOSED RULES
HEALTH CARE AUTHORITY
(School Employees Benefits Board)
[Admin #2021-01.01—Filed April 30, 2021, 3:19 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 21-04-109.

Title of Rule and Other Identifying Information: WAC 182-31-050 When does eligibility for the employer contribution for school employees benefits board (SEBB) benefits end?

Hearing Location(s): On June 8, 2021, at 10:00 a.m. In response to the coronavirus disease 2019 (COVID-19) public health emergency, the agency will not provide a physical location for this hearing. This promotes 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 attend the virtual public hearing, you must register at the following link https://attendee.gotowebinar.com/register/8620587191761803532, Webinar ID 384-227-715. After registering, you will receive a confirmation email containing the information about joining the webinar.

Date of Intended Adoption: Not sooner than June 9, 2021.

Submit Written Comments to: Health Care Authority (HCA) Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, by June 8, 2021.

Assistance for Persons with Disabilities: Contact Amber Lougheed, phone 360-725-1349, fax 360-586-9727, telecommunication[s] relay service 711, email amber.lougheed@hca.wa.gov, by May 21, 2021.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The purpose of this proposal is to implement a policy resolution to support the SEBB program.

Amended WAC 182-31-050 to implement Policy Resolution SEBB 2021-01 amending resolution SEBB 2018-25 when the employer contribution for SEBB benefits end.

Reasons Supporting Proposal: See purpose statement.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160; policy resolution SEBB 2021-01.

Statute Being Implemented: RCW 41.05.021, 41.05.160.

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: Not applicable.

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Stella Ng, 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.

April 30, 2021
Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 20-16-067, filed 7/28/20, effective 8/28/20)

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;

(d) The school employee who returns from approved leave without pay, who maintained or established eligibility as described in WAC 182-31-040 (4)(d), and who subsequently has a change in work pattern that, had the work pattern been in effect at the start of the school year, would not 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. In this case, eligibility for the employer contribution ends as of the last day of the month in which the change is effective;

(e) The nine to ten month school employee hired late in the year and eligible for the employer contribution as described in WAC 182-31-040 (4)(c)(i), who subsequently has a change in work pattern such that the school employee is no longer eligible under the criteria described in WAC 182-31-040 (4)(c)(i). In this case, eligibility for the employer contribution ends as of the last day of the month in which the change is effective;

(f) The twelve month school employee hired late in the year and eligible for the employer contribution as described in WAC 182-31-040 (4)(c)(ii), who subsequently has a change in work pattern such that the school employee is no longer eligible under the criteria described in WAC 182-31-040 (4)(c)(ii). In this case, eligibility for the employer contribution ends as of the last day of the month in which the change is effective; or

(g) The school employee hired later in the year and eligible for the employer contribution as described in WAC 182-31-040 (4)(c), who is no longer anticipated to work six hundred thirty hours the next school year. In this case, eligibility for the employer contribution ends as of the last day of the month in which the change in the anticipation occurs.

(2) If the SEBB organization deducted the school employee's portion of the premium for SEBB 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.

WSR 21-10-062
PROPOSED RULES
HEALTH CARE AUTHORITY
(School Employees Benefits Board)

[Admin #2021-01.02—Filed April 30, 2021, 3:34 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 21-04-109.

Title of Rule and Other Identifying Information: 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, 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?, and 182-31-160 National Medical Support Notice (NMSN).

Hearing Location(s): On June 8, 2021, at 10:00 a.m. In response to the coronavirus disease 2019 (COVID-19) public health emergency, the agency will not provide a physical location for this hearing. This promotes 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 attend the virtual public hearing, you must register at the following link https://attendee.gotowebinar.com/register/8620587191761803532, Webinar ID 384-227-715. After registering, you will receive a confirmation email containing the information about joining the webinar.

Date of Intended Adoption: Not sooner than June 9, 2021.

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 June 8, 2021.

Assistance for Persons with Disabilities: Contact Amber Lougheed, phone 360-725-1349, fax 360-586-9727, telecommunication[s] relay service 711, email amber.lougheed@hca.wa.gov, by May 21, 2021.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The purpose of this proposal is to amend rules to support the SEBB program.

1. Implement SEBB policy resolutions related to dual enrollment prohibitions between SEBB and public employees benefits board (PEBB) programs and long-term disability insurance enrollment procedures:

Amended WAC 182-30-070, 182-31-070, 182-31-080, and 182-31-160 to implement the following dual enrollment related SEBB policy resolutions:

- SEBB 2021-02 Amending Resolution SEBB 2018-53 School employees may waive enrollment in medical.
- SEBB 2021-03 SEBB benefit enrollment requirements when PEBB benefits are waived.
- SEBB 2021-04 Resolving dual enrollment when a school employee's only medical enrollment is in PEBB.
- SEBB 2021-05 Resolving dual enrollment involving dual subscriber eligibility.
- SEBB 2021-06 Resolving dual enrollment involving a SEBB dependent with multiple medical enrollments.
- SEBB 2021-07 Resolving dual enrollment involving a member with multiple medical enrollments as a dependent.
- SEBB 2021-08 SEBB benefit automatic enrollments when PEBB benefits are auto-disenrolled.
- SEBB 2021-09 Enrollment requirements when a school employee loses dependent coverage in PEBB benefits.

Amended WAC 182-31-080 to implement policy resolution SEBB 2021-11 Employee-paid long-term disability enrollment procedures.

2. Make other technical amendments:

- Amended WAC 182-31-080 to clarify when a school employee may waive SEBB medical during a special enrollment event and to clarify what a special open enrollment event is.

Reasons Supporting Proposal: See purpose statement.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160; policy resolutions SEBB 2021-02, SEBB 2021-03, SEBB 2021-04, SEBB 2021-05, SEBB 2021-06, SEBB 2021-07, SEBB 2021-08, SEBB 2021-09, SEBB 2021-11.

Statute Being Implemented: RCW 41.05.021, 41.05.160.

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: Not applicable.

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Stella Ng, 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.

April 30, 2021

Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 20-16-067, filed 7/28/20, effective 8/28/20)

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 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 for school employees.

(3) 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~~)) enrollment is waived as described in WAC 182-31-080, except for school employees eligible under WAC 182-30-130.

AMENDATORY SECTION (Amending WSR 20-16-067, filed 7/28/20, effective 8/28/20)

WAC 182-31-070 Is dual enrollment in school employees benefits board (SEBB) and public employees benefits board (PEBB) prohibited? School employees benefits board (SEBB) medical, dental, and vision coverage is limited to a single enrollment per individual as described in subsections (1) through (5) of this section. Effective January 1, 2022, individuals are limited to a single enrollment in medical, dental, and vision plans in either the SEBB program or public employees benefits board (PEBB) program as described in subsection (6) of this section.

(1) An individual who has more than one source of eligibility for enrollment in SEBB medical, SEBB dental, and SEBB 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 SEBB medical plan of their spouse, state registered domestic partner, or parent as described in WAC 182-31-080.

(3) A dependent enrolled in SEBB medical, SEBB dental, or SEBB 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 take action to remove the school employee (who is enrolled as a dependent) from their subscriber account, the SEBB program will ((~~terminate~~)) automatically disenroll 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 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 medical as a dependent.

(4) A child who is eligible for SEBB medical, SEBB dental, and SEBB vision under two subscribers may be enrolled 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 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 must notify their other SEBB organization no later than sixty days from the date of loss of the first SEBB 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.

(6) An individual who has more than one source of eligibility for enrollment in the SEBB and PEBB programs is limited to a single enrollment in medical, dental, and vision plans in either the SEBB or PEBB program. If the individual takes no action to resolve the dual enrollment, the SEBB program or the PEBB program will automatically enroll or automatically disenroll the individual as described in this subsection.

(a) An eligible school employee may waive enrollment in SEBB medical to enroll in PEBB medical only if they are enrolled in PEBB dental as described in WAC 182-31-080. A

school employee who waives enrollment in SEBB medical to enroll in PEBB medical also waives enrollment in SEBB dental and SEBB vision.

(b) An employee in the PEBB program who waives PEBB medical and PEBB dental for SEBB medical must be enrolled in SEBB dental and SEBB vision. If necessary, the SEBB program will automatically enroll the individual in the associated subscriber's SEBB dental and SEBB vision.

(c) If the school employee is enrolled only in SEBB dental and SEBB vision, and is also enrolled in PEBB medical, and no action is taken to resolve their dual enrollment, the school employee will remain in PEBB medical. The SEBB program will automatically disenroll the school employee from SEBB dental and SEBB vision in which they are enrolled. The school employee's enrollment in SEBB program life insurance, accidental death and dismemberment (AD&D) insurance, and long-term disability (LTD) insurance will remain.

(d) If the school employee is enrolled in SEBB medical and is also an employee in the PEBB program enrolled in PEBB medical, and the school employee has been enrolled in PEBB medical longer than they have been enrolled in SEBB medical, and no action is taken by the school employee to resolve their dual enrollment, they will remain in PEBB medical. The SEBB program will automatically disenroll the school employee from SEBB medical, SEBB dental, and SEBB vision. The school employee's enrollment in SEBB program life insurance, AD&D insurance, and LTD insurance will remain. If the school employee eligible under both the SEBB program as a school employee and the PEBB program as an employee is not enrolled in any medical, but is enrolled only in PEBB dental, SEBB dental, and SEBB vision, the school employee will remain in SEBB dental and SEBB vision. The PEBB program will automatically disenroll the employee from PEBB dental.

(e) If the school employee's dependent is enrolled in any SEBB medical, SEBB dental, or SEBB vision plan, and the dependent is also an employee in the PEBB program and enrolled in PEBB medical, and no action is taken by either the school employee or the dependent to resolve the dependent's dual enrollment, the school employee's dependent will remain in PEBB medical. The SEBB program will automatically disenroll the school employee's dependent from SEBB medical, SEBB dental, and SEBB vision in which they are enrolled.

(f) If the school employee's dependent is enrolled in both SEBB medical and PEBB medical as a dependent and has been enrolled in PEBB medical longer than they have been enrolled in SEBB medical, and no action is taken to resolve the dual enrollment, the school employee's dependent will remain in PEBB medical. The SEBB program will automatically disenroll the school employee's dependent from SEBB medical, SEBB dental, and SEBB vision if they are enrolled. If the school employee's dependent who is eligible as a dependent in both the SEBB and PEBB programs is not enrolled in any medical but is enrolled only in PEBB dental and SEBB vision (with or without SEBB dental) as a dependent, the dependent will remain in SEBB vision and if enrolled, SEBB dental. The PEBB program will automatically disenroll the dependent from PEBB dental.

Exception: If there is a National Medical Support Notice (NMSN) or a court order in place, enrollment will be in accordance with the NMSN or order.

(g) If the school employee's dependent, who is also an employee in the PEBB program who the PEBB program automatically disenrolled from PEBB dental, the SEBB program will automatically enroll the school employee's dependent in SEBB vision. The SEBB program will also automatically enroll the school employee's dependent in SEBB dental, if they are not already enrolled.

(h) If the school employee who is eligible for the employer contribution toward SEBB benefits was enrolled as a dependent in PEBB medical and PEBB dental and is removed by the PEBB subscriber, the school employee will be required to return from waived enrollment as described in WAC 182-31-080 (3)(b).

AMENDATORY SECTION (Amending WSR 20-16-067, filed 7/28/20, effective 8/28/20)

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 only 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 SEBB dental, SEBB vision, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, and ((~~basic~~)) employer-paid long-term disability (LTD) insurance. A school employee will also be enrolled in employee-paid LTD insurance automatically unless the school employee declines their employee-paid LTD insurance as described in WAC 182-30-080.

Exception: A school employee may waive their enrollment in SEBB medical to enroll in public employees benefits board (PEBB) medical only if they are enrolled in PEBB dental. A school employee who waives enrollment in SEBB medical to enroll in PEBB medical also waives enrollment in SEBB dental and SEBB vision.

(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 only if they are enrolled in other employer-based group medical, a TRICARE plan, or medicare as described in subsection (4) of this section. A special open enrollment event must be an event other than a school employee gaining initial eligibility or regaining eligibility for SEBB benefits.

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 on the first day of the month in which the event occurs. SEBB medical 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).

If a school employee who is eligible for the employer contribution toward SEBB benefits was enrolled as a dependent in PEBB medical and PEBB dental and is removed by the PEBB subscriber, the health care authority will notify the school employee of their removal from the PEBB subscriber's account and that they have experienced a special enrollment event. The school employee will be required to return from waived enrollment and elect SEBB medical, SEBB dental, and SEBB vision. If the school employee's SEBB organization does not receive the school employee's required forms indicating their medical, dental, and vision elections within sixty days of the school employee losing PEBB medical and PEBB dental, they will be defaulted into employee-only SEBB medical, SEBB dental, and SEBB vision as described in WAC 182-30-080 (1)(b)(i) through (iii).

(4) **Special open enrollment:** Any one of the events in (a) through (k) of this subsection may create a special open enrollment that allows the school employee to enroll in SEBB medical after having waived 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 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 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 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 20-16-067, filed 7/28/20, effective 8/28/20)

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 dependent is enrolled in both public employees benefits board medical and SEBB medical as a dependent as described in WAC 182-31-070 (6)(f) and there is a NMSN in place, enrollment will be in accordance with the NMSN; or

(vi) 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 health plan coverage prospectively.

WSR 21-10-063
PROPOSED RULES
HEALTH CARE AUTHORITY
(School Employees Benefits Board)

[Admin #2021-01.03—Filed April 30, 2021, 3:47 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 21-04-109.

Title of Rule and Other Identifying Information: WAC 182-30-040 Premium payments and premium refunds, 182-30-060 How do school employees benefits board (SEBB) organizations and contracted vendors correct enrollment errors?, 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?, 182-31-040 How do school employees establish eligibility for the employer contribution toward school employees benefits board (SEBB) benefits and when do SEBB benefits begin?, 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?, and 182-31-120 What options for continuation coverage are available to school employees during their appeal of a grievance?

Hearing Location(s): On June 8, 2021, at 10:00 a.m. In response to the coronavirus disease 2019 (COVID-19) public health emergency, the agency will not provide a physical location for this hearing. This promotes 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 attend the virtual public hearing, you must register at the following link https://attendee.gotowebinar.com/register/8620587191761803532, Webinar ID 384-227-715. After registering, you will receive a confirmation email containing the information about joining the webinar.

Date of Intended Adoption: Not sooner than June 9, 2021.

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 June 8, 2021.

Assistance for Persons with Disabilities: Contact Amber Lougheed, phone 360-725-1349, fax 360-586-9727, telecommunication[s] relay service 711, email amber.lougheed@hca.wa.gov, by May 21, 2021.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The purpose of this proposal is to amend rules to support the SEBB program.

1. Implement SEBB policy resolutions related to long-term disability insurance (LTD) enrollment and eligibility requirements:

Amended WAC 182-30-040, 182-30-060, 182-30-080, 182-31-040, and 182-31-120 to implement the following LTD insurance related SEBB policy resolutions:

- SEBB 2021-11 Employee-paid long-term disability (LTD) enrollment procedures.
- SEBB 2021-12 Amending Resolution SEBB 2018-54 relating to default enrollments.

2. Make other technical amendments:

- Amended WAC 182-30-040 to include premiums and applicable premium surcharges are due to the contracted vendor, to change the accounting adjustment period from three months to sixty days, and to specify SEBB insurance coverage.
- Amended WAC 182-30-060 to change medical flexible spending arrangement or dependent care assistant program enrollment from three months to sixty days prior to the date enrollment is processed and to clarify recourse rule on when school employee eligibility for SEBB benefits begins.
- Amended WAC 182-30-080 to clarify information a school employee must indicate when completing required forms, to clarify when the employee's request for a change in their supplemental life insurance becomes effective, and to update a WAC reference.
- Amended WAC 182-31-040 to reorder the eligibility criteria when determining school employees' eligibility.
- Amended WAC 182-31-110 to change supplemental LTD insurance to employee-paid LTD insurance.

Reasons Supporting Proposal: See purpose statement.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160; policy resolutions SEBB 2021-11 and SEBB 2021-12.

Statute Being Implemented: RCW 41.05.021, 41.05.160.

Rule is necessary because of federal law, 42 C.F.R. § 423.46 and 423.286.

Agency Comments or Recommendations, if any, as to Statutory Language, Implementation, Enforcement, and Fiscal Matters: Not applicable.

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Stella Ng, 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.

April 30, 2021
Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 20-16-067, filed 7/28/20, effective 8/28/20)

WAC 182-30-040 Premium payments and premium refunds. School employees benefits board (SEBB) 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 insurance coverage premiums and applicable premium surcharges for all subscribers become due the first of the month in which SEBB insurance coverage is effective.

Premiums and applicable premium surcharges are due from the subscriber for the entire month of SEBB 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, 182-31-100, 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 or contracted vendor. If a school employee elects supplemental coverage((~~,~~)) or employee-paid long-term disability (LTD) insurance, or is enrolled in employee-paid LTD insurance, as described in WAC 182-30-080 (1)(a) or (3)(a) or is enrolled in employee-paid LTD insurance as described in WAC 182-30-080 (1)(b) the school employee is responsible for payment of premiums from the month the supplemental coverage or employee-paid LTD insurance 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, 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, 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 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 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~~)) sixty day 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 20-16-066, filed 7/28/20, effective 8/28/20)

WAC 182-30-060 How do school employees benefits board (SEBB) organizations and contracted vendors correct enrollment errors? (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~~)) employer-paid long-term disability (LTD) insurance, and employee-paid LTD insurance (unless the school employee declines the employee-paid LTD insurance as described in WAC 182-30-080(1)) 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~~)) employee-paid 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~~)) employee-paid LTD insurance while on leave without pay as described in WAC 182-31-100. ((~~Supplemental~~)) Employee-paid 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~~)) sixty days 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~~)) employer-paid LTD insurance 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~~)) employee-paid 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 or the first day of work for school employees who start on or before the first day of school 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.

AMENDATORY SECTION (Amending WSR 20-16-067, filed 7/28/20, effective 8/28/20)

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~~)) enrollment 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 ((~~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. A school employee may apply for enrollment in supplemental life ((~~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. For a school employee who requests a change in their supplemental life insurance after the election period described in this subsection, the change begins the first day of the month following the date the contracted vendor approves the request. 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) School employees are enrolled in employee-paid long-term disability (LTD) insurance automatically. A school employee may elect to reduce their employee-paid LTD insurance or decline their employee-paid LTD insurance by returning the form to their SEBB organization. A school employee may apply for a change in their employee-paid LTD insurance at any time during the calendar year by submitting the required form to their SEBB organization or the contracted vendor. For a school employee who requests a change in their employee-paid LTD insurance after the election period described in this subsection, the change begins the first day of the month following the date the SEBB organization receives the required form requesting to reduce or decline the employee-paid LTD insurance, or the day of the month the contracted vendor approves the required form to increase the employee-paid LTD insurance.

(iii) 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~~))) (iv) 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 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 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 determined by the health care authority (HCA);

(ii) A dental plan determined by the HCA;

(iii) A vision plan determined by the HCA;

(iv) Basic life insurance;

(v) Basic AD&D insurance;

(vi) ((~~Basic~~)) Employer-paid LTD insurance and employee-paid 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 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, including following a period of leave as described in WAC 182-31-100(1) or ((~~182-31-040(6)~~)) 182-31-040 (4)(d), SEBB medical, dental, and vision begin the first day of the month following the school employee's return to work if the SEBB organization anticipates the school employee is eligible for the employer contribution.

(a) A school employee must complete the required forms indicating their enrollment elections, including an election to waive ((~~SEBB medical~~)) enrollment if the school employee chooses to waive ((~~SEBB medical~~)) enrollment 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 life insurance or supplemental AD&D coverage after losing eligibility will maintain that level of coverage upon return;

(ii) A school employee who was eligible to continue supplemental life ((~~or supplemental AD&D~~)) insurance but dis-

continued that ((~~SEBB~~)) 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~~)) employee-paid LTD insurance elections. Their ((~~supplemental~~)) employee-paid 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 regaining eligibility, the school employee's enrollment for those elections not received will be as described in subsection (1)(b)(i) through (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 SEBB benefits, the school employee must return the required form to the contracted vendor 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 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 benefits elections also remain the same when a school employee has a break in employment that does not interrupt their employer contribution toward SEBB 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 20-16-064, filed 7/28/20, effective 8/28/20)

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 begin? (1) Eligibility shall be determined solely by the criteria that most closely describes the school employee's work circumstance.

(2) 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 school employees benefits board (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.

(3) 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.

(4) School employee eligibility criteria shall be determined in the following order:

(a) A school employee is eligible for the employer contribution toward ((~~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~~)) presumed eligible for the employer contribution ((~~toward 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~~)) at the start of the school year, as described in (a) of this subsection, if they:

(i) Worked at least six hundred thirty hours in each of the previous two school years; and

(ii) 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.

(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 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 eli-

gibility 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~~)) (d) 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.

(5) A school employee ((~~in their capacity as a school employee must be included in the calculation of~~)) who is not anticipated to work at least six hundred thirty 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 as described in subsection (4)(a) of this section, may later be eligible for SEBB benefits when:

(a) Their work pattern is revised in such a way that they are now anticipated to work six hundred thirty hours in the school year. The school employee becomes eligible for the employer contribution toward SEBB benefits on the date their work pattern is revised; or

(b) They actually worked six hundred thirty hours in the school year. The school employee becomes eligible for the employer contribution toward SEBB benefits on the date they actually worked six hundred thirty hours.

(((~~(4) A~~)) (6) If the 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~~)) is not eligible under subsection (4) or (5) 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.

(7) When SEBB benefits begin:

(a) For a school employee who establishes eligibility under subsection (((~~(2)~~))) (4)(a)(i) of this section, medical, dental, vision, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, ((~~basic~~)) employer-paid long-term disability (LTD) insurance, employee-paid LTD insurance (unless the school employee declines the employee-paid LTD insurance as described in WAC 182-30-080(1)), and if eligible, benefits under the salary reduction plan begin on the first day of work for the new school year. Supplemental life insurance((~~,~~)) and 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)~~))) (4)(a)(ii), (((~~(b),~~)) (c), (d), or (((~~(6)~~))) (5) of this section, medical, dental, vision, basic life insurance, basic AD&D insurance, ((~~basic~~)) employer-paid LTD insurance, employee-paid LTD insurance (unless the school employee declines the employee-paid LTD insurance as described in WAC 182-30-080(1)), and if eligible, benefits under the salary reduction plan begin on the first day of the month following the date the school employee becomes eligible for the employer contribution toward SEBB benefits. Supplemental life insurance((~~,~~)) and 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)~~))) (4)(d) or (5) 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.

(((~~(8) If the school employee is not eligible under subsections (1) through (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.~~)))

AMENDATORY SECTION (Amending WSR 20-16-067, filed 7/28/20, effective 8/28/20)

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) may continue to receive the employer contribution toward school employees benefits board (SEBB) benefits in accordance with the federal FMLA. The school employee may also continue current supplemental life, supplemental accidental death and dismemberment (AD&D), and ((~~supplemental~~)) employee-paid 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.

(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~~)) employee-paid 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 20-16-067, filed 7/28/20, effective 8/28/20)

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;

(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 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 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)(c).

(3) If the dismissal is upheld, all SEBB insurance coverage will 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 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 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, and employee-paid long-term disability (LTD) 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 and employee-paid LTD insurance 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 enroll in such supplemental coverage and employee-paid LTD insurance.

WSR 21-10-065
PROPOSED RULES
HEALTH CARE AUTHORITY
(School Employees Benefits Board)

[Admin #2021-01.04—Filed April 30, 2021, 3:58 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 21-04-109.

Title of Rule and Other Identifying Information: **The following sections in chapter 182-30 WAC are revised:** WAC 182-30-020 Definitions, 182-30-030 Employer contribution for school employees benefits board (SEBB) benefits, 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)?, 182-30-130 What are the requirements for a school employees benefits board (SEBB) organization engaging in local negotiations regarding SEBB benefits eligibility criteria?, and 182-30-140 What is the process for school districts to offer optional benefits?

The following sections in chapter 182-31 WAC are revised: WAC 182-31-020 Definitions, 182-31-090 When is an enrollee eligible to continue school employees benefits board (SEBB) benefits under Consolidated Omnibus Budget Reconciliation Act (COBRA)?, and 182-31-150 When may subscribers enroll or remove eligible dependents?

The following sections in chapter 182-32 WAC are revised: WAC 182-32-020 Definitions and 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.

Hearing Location(s): On June 8, 2021, at 10:00 a.m. In response to the coronavirus disease 2019 (COVID-19) public health emergency, the agency will not provide a physical location for this hearing. This promotes 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 attend the virtual public hearing, you must register at the following link https://attendee.gotowebinar.com/register/8620587191761803532, Webinar ID 384-227-715. After registering, you will receive a confirmation email containing the information about joining the webinar.

Date of Intended Adoption: Not sooner than June 9, 2021.

Submit Written Comments to: Health care authority (HCA) Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, by June 8, 2021.

Assistance for Persons with Disabilities: Contact Amber Lougheed, phone 360-725-1349, fax 360-586-9727, telecommunication[s] relay service 711, email amber.lougheed@hca.wa.gov, by May 21, 2021.

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 SEBB program:

1. Make technical amendments:

- Amended WAC 182-30-090 to clarify special open enrollment opportunities only apply if the dependent is a tax dependent.
- Amended WAC 182-30-090 and 182-30-100 to remove the restriction when a subscriber has a change in health plan based on the location of their employment.
- Amended WAC 182-30-130 to include supplemental accidental death and dismemberment insurance in the list of benefits that are not available to school employees whose eligibility is negotiated locally.
- Amended WAC 182-30-140 to clarify optional benefits must be paid for by the school employee without an employer contribution, except for when they participate in Voluntary Employees' Beneficiary Association account.
- Amended WAC 182-31-090 to include when an enrollee's Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage will terminate upon eligibility for medicare due to age or when enrolled in medicare due to a disability.
- Amended WAC 182-31-150 to include a special open enrollment event when a subscriber's dependent enrolls in medicare or loses eligibility for medicare, and to clarify a subscriber must certify the state registered domestic partner or state registered domestic partner's child is a tax dependent.
- Amended WAC 182-32-2020 to clarify disability insurance is long-term disability insurance.

2. Amend rules to improve the administration of the SEBB program:

- Amended WAC 182-30-020 and 182-31-020 to update the definitions of annual open enrollment, long-term disability insurance or LTD insurance, special open enrollment, supplemental coverage, and waive.
- Amended WAC 182-30-030 to change basic long-term disability insurance to employer-paid long-term disability insurance.
- Amended WAC 182-31-090 to clarify a school employee or a school employee's dependent may continue coverage if they lose eligibility for continuation coverage but have not used the maximum number of months allowed under COBRA, and to include additional WAC section references that relate to the effective date of COBRA coverage when an enrollee loses eligibility for SEBB health plan coverage.
- Amended WAC 182-32-020 to update the definition of long-term disability insurance or LTD insurance, to remove the definition of disability insurance, and to amend the definition of file or filing to include delivery methods for filing an appeal.

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, 26 U.S.C. § 105, 106, and 152; and 42 C.F.R. § 406.24.

Agency Comments or Recommendations, if any, as to Statutory Language, Implementation, Enforcement, and Fiscal Matters: Not applicable.

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Stella Ng, 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.

April 30, 2021
Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 20-16-067, filed 7/28/20, effective 8/28/20)

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~~)) (see definition of "waive" in this section). 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 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 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 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 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 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" means ((~~any basic~~)) employer-paid long-term disability insurance ((~~paid for by the SEBB organization~~)) and any ((~~supplemental~~)) employee-paid long-term disability insurance offered ((~~to and paid for by the school employee~~)) by the SEBB program.

"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 reduc-

tion 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.

"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.

"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~~)) (see definition of "waive" in this section). 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((~~,~~)) or 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 SEBB medical because the school employee is enrolled in other employer-based group medical, a TRICARE plan, or medicare as allowed under WAC 182-31-080. A school employee may waive enrollment in SEBB medical to enroll in PEBB medical only if they are enrolled in PEBB dental. A school employee who waives enrollment in SEBB medical to enroll in PEBB medical also waives enrollment in SEBB dental and SEBB vision.

"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 182-30-030 Employer contribution for school employees benefits board (SEBB) benefits. The employer contribution must be used to provide school employees benefits board (SEBB) insurance coverage for the basic life insurance benefit, basic accidental death and dismemberment (AD&D) insurance benefit, ((~~basic~~)) employer-paid long-term disability (LTD) insurance benefit, medical insurance, vision insurance, dental insurance, SEBB program administrative costs, the school employee remittance required in RCW 28A.400.410 and to establish a reserve for any remaining balance. There is no employer contribution available for any other insurance coverage for school employees employed by SEBB organizations.

AMENDATORY SECTION (Amending WSR 20-16-067, filed 7/28/20, effective 8/28/20)

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 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, 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.

Note: A subscriber may not change their health plan if their state registered domestic partner or state registered domestic partner's child is not a tax dependent.

(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 (e) 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.

(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 fifty miles of the subscriber's new 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 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 enrolls in coverage under medicare, or the subscriber or a subscriber's dependent loses eligibility for coverage under medicare. If the subscriber's current medical plan becomes unavailable due to the subscriber's or a subscriber's dependent's enroll-

ment in medicare, the subscriber must select a new medical plan as described in WAC 182-30-085(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 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 20-16-067, filed 7/28/20, effective 8/28/20)

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: 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 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 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 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 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 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 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.

AMENDATORY SECTION (Amending WSR 20-16-065, filed 7/28/20, effective 8/28/20)

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 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; and

(e) Supplemental accidental death and dismemberment 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.

AMENDATORY SECTION (Amending WSR 20-16-067, filed 7/28/20, effective 8/28/20)

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 must be paid for by the school employee without an employer contribution, except for when a school employee participates in voluntary employees' beneficiary association accounts (VEBA), which may have an employer contribution as described in RCW 28A.400.210(3). 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.~~)) VEBA.

(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).

AMENDATORY SECTION (Amending WSR 20-16-067, filed 7/28/20, effective 8/28/20)

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, enroll in coverage, or waive enrollment ((~~in SEBB medical~~)) (see definition of "waive" in this section). 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 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 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.

"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 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'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" means ((~~any basic~~)) employer-paid long-term disability insurance ((~~paid for by the SEBB organization~~)) and ((~~supplemental~~)) employee-paid long-term disability insurance offered ((~~to and paid for by the school employee~~)) by the SEBB program.

"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.

"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.

"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~~)) (see definition of "waive" in this section). 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((,)) or 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 SEBB medical because the school employee is enrolled in other employer-based group medical, a TRICARE plan, or medicare as allowed under WAC 182-31-080. A school employee may waive enrollment in SEBB medical to enroll in PEBB medical only if they are enrolled in PEBB dental. A school employee who waives enrollment in SEBB medical to enroll in PEBB medical also waives enrollment in SEBB dental and SEBB vision.

"Week" means a seven-day period starting on Sunday and ending on Saturday.

AMENDATORY SECTION (Amending WSR 20-16-067, filed 7/28/20, effective 8/28/20)

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 who loses eligibility for continuation coverage described in WAC 182-31-100, 182-31-110, or 182-31-120 but who has not used the maximum number of months allowed under COBRA may continue any combination of SEBB medical, dental, or vision for the remaining difference in months.

(3) An enrollee may continue SEBB medical, dental, or vision under COBRA by self-paying the premium and applicable premium surcharges set by the health care authority (HCA):

(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~~)) enrollee'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 terminate 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~~))) (4) 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~~))) (5) 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~~)) SEBB health plan coverage as described in WAC 182-31-050, 182-31-100, 182-31-120, or 182-31-140.

(6) An enrollee's COBRA coverage will terminate at the end of the month when they become eligible for medicare due

to turning age sixty-five or older, or when enrolled in medicare due to a disability.

AMENDATORY SECTION (Amending WSR 20-16-067, filed 7/28/20, effective 8/28/20)

WAC 182-31-150 When may subscribers enroll or remove eligible dependents? (1) **Enrolling dependents in school employees benefits board (SEBB) 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. 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 the dependent's effective date will be as follows:

(i) SEBB health plan coverage will be the same as the subscriber's effective date;

(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 health plan coverage begins January 1st of the following year;

(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 182-31-160; 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 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 include, but are not limited to:

(i) The dependent may lose eligibility to continue 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;

(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 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 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 health plan coverage prospectively. SEBB 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 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) SEBB health plan coverage for an extended dependent or a dependent with a disability will begin the first day

of the month following the later of the event date or eligibility certification.

(iii) The dependent will be removed from the subscriber's SEBB 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 health plan coverage will begin or end as follows:

• For the newly born child, SEBB health plan coverage will begin the date of birth;

• For a newly adopted child, SEBB 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.

(b) Any one of the following events may create a special open enrollment:

(i) Subscriber acquires a new dependent due to:

• Marriage or registering a state registered domestic partnership;

• Birth, adoption, or when a 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) 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);

(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;

(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 (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.

(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;

(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;

(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);

(viii) Subscriber or a subscriber's dependent 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;

(ix) Subscriber or a subscriber's dependent becomes eligible for state premium assistance subsidy for SEBB health plan coverage from medicaid or CHIP;

(x) Subscriber's dependent enrolls in medicare, or loses eligibility for medicare.

(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.

Note: When enrolling a state registered domestic partner or a state registered domestic partner's child, a subscriber must certify that the state registered domestic partner or state registered domestic partner's child is a tax dependent on the required form; otherwise, the SEBB program will assume the state registered domestic partner or state registered domestic partner's child is not a tax dependent.

(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 child reaches age twenty-six or within the relevant time frame described in (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 20-16-067, filed 7/28/20, effective 8/28/20)

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, 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 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.

"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 authority or its designee. A document may be filed by one or more of the following:

• Personal delivery to the authority at Cherry Street Plaza, 626 8th Avenue S.E., Olympia, Washington 98501;

• First class, registered, or certified mail to the authority to the following mailing address:

Health Care Authority
Attn: SEBB Appeals Unit
P.O. Box 45504
Olympia, WA 98504-5504;

• Fax: 360-763-4709; or

• Submission online through the designated submission portal.

The identified methods are the exclusive methods for a document to be filed, and submission of documents by any other fashion to the authority shall not constitute filing unless agreed to in advance by the authority.

"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 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" means ((~~basic~~)) employer-paid long-term disability insurance ((~~paid for by the SEBB organization~~)) and ((~~supplemental~~)) employee-paid long-term disability insurance offered ((~~to and paid for by the school employee~~)) by the SEBB program.

"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.

"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, 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 benefit board.

"SEBB" means the school employees benefits board.

"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 20-16-067, filed 7/28/20, effective 8/28/20)

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, 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 SEBB medical, dental, and vision, 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.

(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.

WSR 21-10-070
PROPOSED RULES
HEALTH CARE AUTHORITY
(Public Employees Benefits Board)

[Admin #2021-01.01—Filed May 3, 2021, 7:53 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 21-04-108.

Title of Rule and Other Identifying Information: WAC 182-12-208 What are the requirements regarding enrollment in dental under public employees benefits board (PEBB) retiree insurance coverage? and 182-12-250 Public employees benefits board (PEBB) insurance coverage eligibility for survivors of emergency service personnel killed in the line of duty.

Hearing Location(s): On June 8, 2021, at 10:00 a.m. In response to the coronavirus disease 2019 (COVID-19) public health emergency, the agency will not provide a physical location for this hearing. This promotes 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 attend the virtual public hearing, you must register at the following link https://attendee.gotowebinar.com/register/8620587191761803532, Webinar ID 384-227-715. After registering, you will receive a confirmation email containing the information about joining the webinar.

Date of Intended Adoption: Not sooner than June 9, 2021.

Submit Written Comments to: Health Care Authority (HCA) Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, by June 8, 2021.

Assistance for Persons with Disabilities: Contact Amber Lougheed, phone 360-725-1349, fax 360-586-9727, telecommunication[s] relay service 711, email amber.lougheed@hca.wa.gov, by May 21, 2021.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The purpose of this proposal is to amend and repeal rules to support the PEBB program.

Implement PEBB policy resolution and make other technical amendments:

Repealed WAC 182-12-208 to implement policy resolution PEBB 2021-01 removing the retiree two-year dental enrollment requirement.

Amended WAC 182-12-250 to implement policy resolution PEBB 2021-01 removing the retiree two-year dental enrollment requirement and to clarify survivors' enrollment requirements when returning to a PEBB health plan following deferment.

Reasons Supporting Proposal: See purpose statement.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160; policy resolution PEBB 2021-01.

Statute Being Implemented: RCW 41.05.021, 41.05.160.

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: Not applicable.

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Stella Ng, 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.

May 3, 2021
Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 20-16-062, filed 7/28/20, effective 1/1/21)

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 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 sur-

vivor 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 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 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 coverage~~)). 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 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.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 182-12-208 What are the requirements regarding enrollment in dental under public employees benefits board (PEBB) retiree insurance coverage?

WSR 21-10-071
PROPOSED RULES
HEALTH CARE AUTHORITY
(Public Employees Benefits Board)

[Admin #2021-01.02—Filed May 3, 2021, 8:02 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 21-04-108.

Title of Rule and Other Identifying Information: WAC 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?, and 182-12-263 National Medical Support Notice (NMSN).

Hearing Location(s): On June 8, 2021, at 10:00 a.m. In response to the coronavirus disease 2019 (COVID-19) public health emergency, the agency will not provide a physical location for this hearing. This promotes 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 attend the virtual public hearing, you must register at the following link https://attendee.gotowebinar.com/register/8620587191761803532, Webinar ID 384-227-715. After registering, you will receive a confirmation email containing the information about joining the webinar.

Date of Intended Adoption: Not sooner than June 8, 2021.

Submit Written Comments to: Health Care Authority (HCA) Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, by June 8, 2021.

Assistance for Persons with Disabilities: Contact Amber Lougheed, phone 360-725-1349, fax 360-586-9727, telecommunication[s] relay service 711, email amber.lougheed@hca.wa.gov, by May 21, 2021.

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 board policy resolutions related to dual enrollment prohibitions between PEBB and school employees benefits board (SEBB) programs:

Amended WAC 182-12-123, 182-12-128, and 182-12-263 to implement the following dual enrollment related PEBB policy resolutions:

- PEBB 2021-02 Employees may waive enrollment in medical.
- PEBB 2021-03 PEBB benefit enrollment requirements when SEBB benefits are waived.

- PEBB 2021-04 Resolving dual enrollment when an employee's only medical enrollment is in SEBB.
- PEBB 2021-05 Resolving dual enrollment involving dual subscriber eligibility.
- PEBB 2021-06 Resolving dual enrollment involving a PEBB dependent with multiple medical enrollments.
- PEBB 2021-07 Resolving dual enrollment involving a member with multiple medical enrollments as a dependent.
- PEBB 2021-08 PEBB benefit automatic enrollments when SEBB benefits are auto-disenrolled.
- PEBB 2021-09 Enrollment requirements when an employee loses dependent coverage in SEBB benefits.

2. Make other technical amendments:

- Amended WAC 182-12-128 to clarify when an employee may waive PEBB medical during a special enrollment event and to clarify what a special open enrollment event is, and to change basic long-term disability insurance to employer-paid long-term disability insurance.

Reasons Supporting Proposal: See purpose statement.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160; policy resolutions PEBB 2021-02, PEBB 2021-03, PEBB 2021-04, PEBB 2021-05, PEBB 2021-06, PEBB 2021-07, PEBB 2021-08, and PEBB 2021-09.

Statute Being Implemented: RCW 41.05.021, 41.05.160.

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: Not applicable.

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Stella Ng, 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.

May 3, 2021
Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 20-16-062, filed 7/28/20, effective 1/1/21)

WAC 182-12-123 Is dual enrollment in public employees benefits board (PEBB) and school employees benefits board (SEBB) prohibited? Public employees benefits board (PEBB) medical and dental coverage is limited to a single enrollment per individual as described in subsections (1) through (5) of this section. Effective January 1, 2022, individuals are limited to a single enrollment in medical, dental, and vision plans in either the PEBB program or school employees benefits board (SEBB) program as described in subsection (6) of this section.

(1) An individual who has more than one source of eligibility for enrollment in PEBB medical and PEBB 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 PEBB medical plan of their spouse, state registered domestic partner, or parent as described in WAC 182-12-128.

(3) A dependent enrolled in PEBB medical or PEBB 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 medical as a dependent. If the employee's spouse, state registered domestic partner, or parent does not take action to remove the employee (who is enrolled as a dependent) from their subscriber account, the PEBB program will ((~~terminate~~)) automatically disenroll 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 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 medical as a dependent.

(4) A child who is eligible for PEBB medical and PEBB dental under two subscribers may be enrolled 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 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 benefits end through

the employing agency described in (a) of this subsection to transfer coverage.

(c) The employee's elections remain the same when an employee transfers their enrollment under one employing agency to another employing agency without a break in PEBB benefits for one month or more, as described in (b) of this subsection.

(6) An individual who has more than one source of eligibility for enrollment in the PEBB and SEBB programs is limited to a single enrollment in medical, dental, and vision plans in either the PEBB or SEBB program. If the individual takes no action to resolve the dual enrollment, the PEBB program or the SEBB program will automatically enroll or automatically disenroll the individual as described in this subsection.

(a) An eligible employee may waive enrollment in PEBB medical to enroll in SEBB medical only if they are enrolled in SEBB dental and SEBB vision as described in WAC 182-12-128. An employee who waives enrollment in PEBB medical to enroll in SEBB medical also waives enrollment in PEBB dental.

(b) A school employee in the SEBB program who waives SEBB medical, SEBB dental, and SEBB vision for PEBB medical must be enrolled in PEBB dental. If necessary, the PEBB program will automatically enroll the individual in the associated subscriber's PEBB dental.

(c) If the employee is enrolled only in PEBB dental, and is also enrolled in SEBB medical, and no action is taken to resolve their dual enrollment, the employee will remain in SEBB medical. The PEBB program will automatically disenroll the employee from PEBB dental in which they are enrolled. The employee's enrollment in PEBB program life insurance, accidental death and dismemberment (AD&D) insurance, and long-term disability (LTD) insurance will remain.

(d) If the employee is enrolled in PEBB medical and is also a school employee in the SEBB program and enrolled in SEBB medical, and the employee has been enrolled in SEBB medical longer than they have been enrolled in PEBB medical, and no action is taken by the employee to resolve their dual enrollment, they will remain in SEBB medical. The PEBB program will automatically disenroll the employee from PEBB medical and PEBB dental. The employee's enrollment in PEBB program life insurance, AD&D insurance, and LTD insurance will remain. If the employee eligible under both the PEBB program as an employee and the SEBB program as a school employee is not enrolled in any medical, but is enrolled only in PEBB dental and SEBB vision (with or without SEBB dental), the employee will remain in SEBB vision and if enrolled, SEBB dental. The PEBB program will automatically disenroll the employee from PEBB dental.

(e) If the employee's dependent is enrolled in any PEBB medical or PEBB dental plan, and the dependent is also a school employee in the SEBB program and enrolled in SEBB medical, and no action is taken by either the employee or the dependent to resolve the dependent's dual enrollment, the employee's dependent will remain in SEBB medical. The PEBB program will automatically disenroll the employee's dependent from PEBB medical and PEBB dental in which they are enrolled.

(f) If the employee's dependent is enrolled in both PEBB medical and SEBB medical as a dependent and has been enrolled in SEBB medical longer than they have been enrolled in PEBB medical, and no action is taken to resolve the dual enrollment, the employee's dependent will remain in SEBB medical. The PEBB program will automatically disenroll the employee's dependent from PEBB medical and PEBB dental if they are enrolled. If the employee's dependent who is eligible as a dependent in both the PEBB and SEBB programs is not enrolled in any medical but is enrolled only in PEBB dental and SEBB vision (with or without SEBB dental) as a dependent, the dependent will remain in SEBB vision and if enrolled, SEBB dental. The PEBB program will automatically disenroll the employee's dependent from PEBB dental.

Exception: If there is a National Medical Support Notice (NMSN) or a court order in place, enrollment will be in accordance with the NMSN or order.

(g) If the employee's dependent, who is also a school employee in the SEBB program who the SEBB program automatically disenrolled from SEBB dental and SEBB vision, the PEBB program will automatically enroll the employee's dependent in PEBB dental, if they are not already enrolled.

(h) If the employee who is eligible for the employer contribution toward PEBB benefits was enrolled as a dependent in SEBB medical, SEBB dental, and SEBB vision and is removed by the SEBB subscriber, the employee will be required to return from waived enrollment as described in WAC 182-12-128 (3)(b).

(7) A retiree who defers enrollment in 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 20-16-062, filed 7/28/20, effective 1/1/21)

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 only 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 PEBB dental, basic life insurance, basic accidental death and dismemberment insurance, and ((~~basic~~)) employer-paid long-term disability (LTD) insurance (unless the employing agency does not participate in these PEBB insurance coverages). For an employing agency that participates in LTD insurance, an employee will also be enrolled in employee-paid LTD insurance automatically unless the employee

declines their employee-paid LTD insurance as described in WAC 182-08-197.

Exception: An employee may waive their enrollment in PEBB medical to enroll in school employees benefits board (SEBB) medical only if they are enrolled in SEBB dental and SEBB vision. An employee who waives enrollment in PEBB medical to enroll in SEBB medical also waives enrollment in PEBB dental.

(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 only if they are enrolled in other employer-based group medical, a TRICARE plan, or medicare as described in subsection (4) of this section. A special open enrollment event must be an event other than an employee gaining initial eligibility or regaining eligibility for PEBB benefits.

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 on the first day of the month in which the event occurs. PEBB medical 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).

If an employee who is eligible for the employer contribution toward PEBB benefits was enrolled as a dependent in SEBB medical, SEBB dental, and SEBB vision and is removed by the SEBB subscriber, the health care authority will notify the employee of their removal from the SEBB subscriber's account and that they have experienced a special enrollment event. The employee will be required to return from waived enrollment and elect PEBB medical and PEBB dental. If the employee's employing agency does not receive the employee's required forms indicating their medical and dental elections within sixty days of the employee losing SEBB medical, SEBB dental, and SEBB vision, they will be defaulted into employee-only PEBB medical and PEBB dental as described in WAC 182-08-197 (1)(b)(i) and (ii).

(4) **Special open enrollment:** Any one of the events in (a) through (k) of this subsection may create a special open enrollment that allows the employee to enroll in PEBB medical after having waived 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 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 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 20-16-062, filed 7/28/20, effective 1/1/21)

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 dependent is enrolled in both school employees benefits board medical and PEBB medical as a dependent as described in WAC 182-12-123 (6)(f) and there is a NMSN in place, enrollment will be in accordance with the NMSN; or

(vi) 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 health plan coverage prospectively.

WSR 21-10-072
PROPOSED RULES
HEALTH CARE AUTHORITY
(Public Employees Benefits Board)

[Admin #2021-01.03—Filed May 3, 2021, 8:11 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 21-04-108.

Title of Rule and Other Identifying Information: WAC 182-08-180 Premium payments and premium refunds, 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, 182-08-197 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?, 182-12-114 How do employees establish eligibility for 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?, and 182-12-148 What options for continuation coverage are available to employees during their appeal of dismissal?

Hearing Location(s): On June 8, 2021, at 10:00 a.m. In response to the coronavirus disease 2019 (COVID-19) public health emergency, the agency will not provide a physical location for this hearing. This promotes 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 attend the virtual public hearing, you must register at the following link https://attendee.gotowebinar.com/register/8620587191761803532, Webinar ID 384-227-715. After registering, you will receive a confirmation email containing the information about joining the webinar.

Date of Intended Adoption: Not sooner than June 9, 2021.

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 June 8, 2021.

Assistance for Persons with Disabilities: Contact Amber Lougheed, phone 360-725-1349, fax 360-586-9727, telecommunication[s] relay service 711, email amber.lougheed@hca.wa.gov, by May 21, 2021.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The purpose of this proposal is to amend rules to support the PEBB program.

1. Implement PEBB policy resolutions related to long-term disability insurance enrollment and eligibility requirements:

Amended WAC 182-08-180, 182-08-187, 182-08-197, 182-12-114, 182-12-133, 182-12-138, and 182-12-148 to implement the following long-term disability insurance related PEBB policy resolutions:

- PEBB 2021-11 Employee-paid long-term disability (LTD) enrollment procedures.
- PEBB 2021-12 Amending resolution PEBB 2020-04 relating to default enrollments.

2. Make other technical amendments:

- Amended WAC 182-08-180 to include medicare Part D late enrollment penalty payment associated with medicare advantage-prescription drug plan be made to the contracted vendor, to include premiums and applicable premium surcharges are due to contracted vendor, to change the accounting adjustment period from three months to sixty days, and to update citations.
- Amended WAC 182-08-187 to change medical flexible spending arrangement or dependent care assistant program enrollment from three months to sixty days prior to the date enrollment is processed.
- Amended WAC 182-08-190 to clarify the entire employer contribution is due and payable to HCA.
- Amended WAC 182-08-197 to clarify when the employee's request for a change in their supplemental life insurance becomes effective and when PEBB medical and dental will begin for a faculty who regains eligibility.
- Amended WAC 182-12-138 to change supplemental LTD insurance to employee-paid LTD insurance and to include a WAC reference.

Reasons Supporting Proposal: See purpose statement.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160; policy resolutions PEBB 2021-11 and PEBB 2021-12.

Statute Being Implemented: RCW 41.05.021, 41.05.160.

Rule is necessary because of federal law, 42 C.F.R. § 423.46 and 423.286.

Agency Comments or Recommendations, if any, as to Statutory Language, Implementation, Enforcement, and Fiscal Matters: Not applicable.

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Stella Ng, 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.

May 3, 2021
Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 20-16-062, filed 7/28/20, effective 1/1/21)

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)~~)) or (7), 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 (LTD) insurance coverage. Any medicare part D late enrollment penalty associated with the medicare advantage-prescription drug plan must be made to the contracted vendor. 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 or contracted vendor. If an employee elects supplemental coverage or employee-paid LTD insurance, or is enrolled in employee-paid LTD insurance as described in WAC 182-08-197 (1)(a) or (3)(a), or is enrolled in employee-paid LTD insurance as described in WAC 182-08-197 (1)(b), the employee is responsible for payment of premiums from the month that the supplemental coverage or employee-paid LTD insurance 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, 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~~)) sixty day 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 20-16-062, filed 7/28/20, effective 1/1/21)

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 (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 benefits as elected by the employee, if the elections were timely;

(c) Failure to enroll an employee and their dependents in PEBB 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.

(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~~)) employer-paid long-term disability (LTD) insurance, and employee-paid LTD insurance (unless the employee declines the employee-paid LTD insurance as described in WAC 182-08-197(1)) 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~~)) employer-paid LTD insurance, and employee-paid LTD insurance begin((~~s~~)) on that date;

(c) Supplemental life, supplemental AD&D, and ((~~supplemental~~)) employee-paid 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 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~~)) employee-paid 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~~)) employee-paid LTD insurance during the period of leave as described in WAC 182-12-133, ((~~supplemental~~)) employee-paid 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~~)) employee-paid 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~~)) sixty days 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 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~~)) employer-paid LTD starting the date PEBB 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 after the employee was notified.

(b) When an employing agency fails to correctly enroll the amount of ((~~supplemental~~)) employee-paid 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 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.

(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 surcharges 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 benefits within the following parameters:

(i) Retroactive enrollment in a PEBB 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

(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 20-16-062, filed 7/28/20, effective 1/1/21)

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 HCA for PEBB 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 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.

(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~~)) enrollment 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 20-16-059, filed 7/28/20, effective 1/1/21)

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~~)) enrollment 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 ((~~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 ((~~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. For an employee who requests a change in their supplemental life insurance after the election period described in this subsection, the change begins the first day of the month following the date the contracted vendor approves the request. An employee may enroll in supplemental accidental death and dismemberment (AD&D) insurance at any time during the calendar year without evidence of insurability by submitting the required form to the contracted vendor.

(ii) Employees are enrolled in employee-paid long-term disability (LTD) insurance automatically. An employee may elect to reduce their employee-paid LTD insurance or decline their employee-paid LTD insurance by returning the form to their employing agency. An employee may apply for a change in their employee-paid LTD insurance at any time during the calendar year by submitting the required form to their employing agency or the contracted vendor. For an employee who requests a change in their employee-paid LTD insurance after the election period described in this subsection, the change begins the first day of the month following the date the employing agency receives the required form requesting to reduce or decline the employee-paid LTD insurance, or the day of the month the contracted vendor approves the required form to increase the employee-paid LTD insurance.

(iii) 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)~~)) (iv) 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 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) A medical plan determined by the health care authority (HCA);

(ii) A dental plan determined by the HCA;

(iii) Basic life insurance;

(iv) Basic AD&D insurance;

(v) ((~~Basic~~)) Employer-paid LTD insurance and employee-paid 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 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 benefits, including following a period of leave described in WAC 182-12-133(1), 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, or the first day of the month in which the quarter or semester begins for faculty who regains eligibility as described in WAC 182-12-131 (3)(e).

(a) An employee must complete the required forms indicating their enrollment elections, including an election to waive ((~~PEBB medical~~)) enrollment if the employee chooses to waive ((~~PEBB medical~~)) enrollment 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 (a)(i) and (b) of this subsection:

(i) An employee who self-paid for supplemental life insurance or supplemental AD&D coverage after losing eligibility will maintain that level of coverage upon return;

(ii) An employee who was eligible to continue supplemental life ((~~or supplemental AD&D~~)) insurance but discontinued that 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~~)) employee-paid LTD insurance but discontinued that ((~~supplemental~~)) coverage must submit evidence of insurability for ((~~supplemental~~)) employee-paid LTD insurance to the contracted vendor when they regain eligibility for the employer contribution.

(b) An employee or faculty in any of the following circumstances does not have to return a form indicating ((~~supplemental~~)) employee-paid LTD insurance elections. Their ((~~supplemental~~)) employee-paid LTD insurance will be automatically reinstated effective the first day of the month they are in pay status eight or more hours or the first day of the month in which the quarter or semester begins for faculty who regains eligibility as described in WAC 182-12-131 (3)(e):

(i) The employee continued to self-pay for their ((~~supplemental~~)) employee-paid LTD insurance after losing eligibility for the employer contribution;

(ii) The employee was not eligible to continue ((~~supplemental~~)) employee-paid 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 for those elections not received will be as described in subsection (1)(b)(i) through (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 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 benefits elections remain the same when an employee transfers from one employing agency to another employing agency without a break in PEBB 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 benefits elections also remain the same when an employee has a break in employment that does not interrupt their employer contribution toward PEBB benefits.

AMENDATORY SECTION (Amending WSR 20-16-062, filed 7/28/20, effective 1/1/21)

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.

For how the employer contribution toward PEBB 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 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 benefits as described in WAC 182-12-131(1).

(d) **When PEBB benefits begin.** Medical, dental, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, ((~~basic~~)) employer-paid long-term disability (LTD) insurance, employee-paid LTD insurance (unless the employee declines the employee-paid LTD insurance as described in WAC 182-08-197(1)), 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 coverage begins on that date. Supplemental life insurance((~~,~~)) and 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 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 benefits as described in WAC 182-12-131(1).

(d) **When PEBB benefits begin.** Medical, dental, basic life insurance, basic AD&D insurance, ((~~basic~~)) employer-paid LTD insurance, employee-paid LTD insurance (unless the employee declines the employee-paid LTD insurance as described in WAC 182-08-197(1)), 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 coverage begins on that date. Supplemental life insurance((~~,~~)) and 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 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 benefits begin.**

(i) Medical, dental, basic life insurance, basic AD&D insurance, ((~~basic~~)) employer-paid LTD insurance, employee-paid LTD insurance (unless the faculty declines the employee-paid LTD insurance as described in WAC 182-08-197(1)), 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 coverage begins on that date. Supplemental life insurance((~~,~~)) and 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, ((~~basic~~)) employer-paid LTD insurance, employee-paid LTD insurance (unless the faculty declines the employee-paid LTD insurance as described in WAC 182-08-197(1)), 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 coverage begins at the beginning of the second consecutive quarter/semester. Supplemental life insurance((~~,~~)) and 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 benefits begin.** Medical, dental, basic life insurance, basic AD&D insurance, ((~~basic~~)) employer-paid LTD insurance, employee-paid LTD insurance (unless the employee declines the employee-paid LTD insurance as described in WAC 182-08-197(1)), 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 coverage begins on that date. Supplemental life insurance((~~,~~)) and 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 benefits begin.** Medical, dental, basic life insurance, basic AD&D insurance, ((~~basic~~)) employer-paid LTD insurance, employee-paid LTD insurance (unless the employee declines the employee-paid LTD insurance as described in WAC 182-08-197(1)), 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 coverage begins on that date. Supplemental life insurance((~~,~~)) and 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 20-16-062, filed 7/28/20, effective 1/1/21)

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 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. 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~~)) employer-paid long-term disability (LTD) insurance or both ((~~basic~~)) employer-paid and ((~~supplemental long-term disability (~~)) employee-paid 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 20-16-062, filed 7/28/20, effective 1/1/21)

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) may continue to receive the employer contribution toward public employees benefits board (PEBB) benefits in accordance with the federal FMLA. The employee may also continue current supplemental life, supplemental accidental death and dismemberment (AD&D), and ((~~supplemental~~)) employee-paid 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.

(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~~)) employee-paid 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 as described in WAC 182-12-133(1).

AMENDATORY SECTION (Amending WSR 20-16-062, filed 7/28/20, effective 1/1/21)

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 cov-

erage 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;

(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 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 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~~)) employee-paid 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 and employee-paid LTD insurance 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 enroll in such supplemental coverage and employee-paid LTD insurance.

WSR 21-10-074
PROPOSED RULES
HEALTH CARE AUTHORITY
(Public Employees Benefits Board)

[Admin #2021-01.04—Filed May 3, 2021, 8:30 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 21-04-108.

Title of Rule and Other Identifying Information: 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 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?, 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 June 8, 2021, at 10:00 a.m. In response to the coronavirus disease 2019 (COVID-19) public health emergency, the agency will not provide a physical location for this hearing. This promotes 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 attend the virtual public hearing, you must register at the following link https://attendee.gotowebinar.com/register/8620587191761803532, Webinar ID 384-227-715. After registering, you will receive a confirmation email containing the information about joining the webinar.

Date of Intended Adoption: Not sooner than June 9, 2021.

Submit Written Comments to: Health Care Authority (HCA) Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, by June 8, 2021.

Assistance for Persons with Disabilities: Contact Amber Lougheed, phone 360-725-1349, fax 360-586-9727, telecommunication[s] relay service 711, email amber.lougheed@hca.wa.gov, by May 21, 2021.

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:

Amended WAC 182-12-200, 182-12-205, and 182-12-265 to implement PEBB policy resolution 2021-14 authorizing a gap of thirty-one days or less between periods of enrollment in qualified coverages during the deferral period.

2. Other technical amendments:

Amended WAC 182-12-205 to create new subsections (7) and (8) moved from subsection (6).

Amended WAC 182-12-265 to clarify a survivor's enrollment requirement when they return from deferral.

Reasons Supporting Proposal: See purpose statement.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160; policy resolution PEBB 2021-14.

Statute Being Implemented: RCW 41.05.021, 41.05.160.

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: Not applicable.

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Stella Ng, 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.

A copy of the detailed cost calculations may be obtained by contacting These rules do not apply to small businesses.

May 3, 2021
Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 20-16-063, filed 7/28/20, effective 1/1/21)

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 enrollment under PEBB retiree insurance coverage? (1) A retiring employee or a retiring school employee may defer enrollment in public employees benefits board (PEBB) retiree insurance coverage at retirement 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 PEBB 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 school employees benefits board (SEBB), including such coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or continuation coverage.

(2) A retiring employee, a retiring school employee, or a retiree who defers enrollment in PEBB retiree insurance coverage defers enrollment in PEBB medical and PEBB dental. A retiree must be enrolled in PEBB medical to enroll in PEBB dental. A retiree who defers enrollment 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 as described in this section may later enroll themselves and their dependents in a PEBB health plan ((~~if they provide~~)) by submitting the required forms as described below and 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 gap of thirty-one days or less is allowed between the date PEBB retiree insurance coverage is deferred and the start date of enrollment in a health plan sponsored by PEBB, a Washington state educational service district, or SEBB, and between each period of enrollment in qualifying coverages as described in WAC 182-12-205 (3)(a) through (e) during the deferral period:

(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).

(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 20-16-063, filed 7/28/20, effective 1/1/21)

WAC 182-12-205 May a retiree or a survivor defer enrollment or voluntarily terminate enrollment under public employees benefits board (PEBB) retiree insurance coverage? (1) The following individuals may defer enrollment in public employees benefits board (PEBB) 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 PEBB 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 enrollment in PEBB retiree insurance coverage must maintain continuous enrollment in ((~~other medical~~)) one or more qualifying coverages as described in this ((~~section~~)) subsection or WAC 182-12-200. A gap of thirty-one days or less is allowed between the date PEBB retiree insurance coverage is deferred and the start date of a qualifying coverage, and between each period of enrollment in qualifying coverages during the deferral period. A subscriber who chooses to defer enrollment, defers enrollment in PEBB medical 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 PEBB 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 PEBB 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 PEBB 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 defined in 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 PEBB retiree insurance coverage when the subscriber is enrolled in exchange coverage.

(e) Beginning July 17, 2018, enrollment in PEBB 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 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 PEBB 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 PEBB 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 cov-

erage, 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 gap of thirty-one days or less is allowed between the date PEBB retiree insurance coverage is deferred and the start date of a qualifying coverage, and between each period of enrollment in qualifying coverages during the deferral period:

(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 defined in 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)~~)) (7) 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 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)~~)) (8) If a subscriber elects to enroll a dependent in PEBB health plan coverage as described in ((~~this~~)) subsection (6) or (7) of this section, 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)~~)) (9) An enrolled retiree or a survivor who requests to voluntarily terminate their enrollment in PEBB 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 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 will terminate on the last day of the month when the medicare advantage plan disenrollment form is received.

AMENDATORY SECTION (Amending WSR 20-16-063, filed 7/28/20, effective 1/1/21)

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. For a survivor to enroll in a PEBB health plan who is not enrolled due to the retiree electing to defer enrollment in PEBB retiree insurance coverage as described in WAC 182-12-200 or 182-12-205, the survivor must also provide evidence of continuous enrollment in ((~~medical coverage~~)) one or more qualifying coverages as described in WAC 182-12-205 (3)(a) through (e) from the most recent open enrollment for which the survivor was not enrolled in a PEBB medical plan prior to the retiree's death. A gap of thirty-one days or less is allowed between the date PEBB retiree insurance coverage was deferred and the start date of a qualifying coverage, and between each period of enrollment in qualifying coverages during the deferral period.

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 PEBB retiree insurance coverage as described in WAC 182-12-200 and 182-12-205.

WSR 21-10-075
PROPOSED RULES
HEALTH CARE AUTHORITY
(Public Employees Benefits Board)

[Admin #2021-01.05—Filed May 3, 2021, 8:40 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 21-04-108.

Title of Rule and Other Identifying Information: WAC 182-12-300 Public employees benefits board (PEBB) wellness incentive program eligibility and procedural requirements.

Hearing Location(s): On June 8, 2021, at 10:00 a.m. In response to the coronavirus disease 2019 (COVID-19) public health emergency, the agency will not provide a physical location for this hearing. This promotes 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 attend the virtual public hearing, you must register at the following link https://attendee.gotowebinar.com/register/8620587191761803532, Webinar ID 384-227-715. After registering, you will receive a confirmation email containing the information about joining the webinar.

Date of Intended Adoption: Not sooner than June 9, 2021.

Submit Written Comments to: Health Care Authority (HCA) Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, by June 8, 2021.

Assistance for Persons with Disabilities: Contact Amber Lougheed, phone 360-725-1349, fax 360-586-9727, telecommunication[s] relay service 711, email amber.lougheed@hca.wa.gov, by May 21, 2021.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The purpose of this proposal is to amend WAC 182-12-300 to support the PEBB program.

Implement PEBB policy resolution:

Amended WAC 182-12-300 to implement policy resolution PEBB 2021-15 rescinding PEBB policy resolution #4 SmartHealth as adopted on July 12, 2017.

Reasons Supporting Proposal: See purpose statement.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160; policy resolution PEBB 2021-15.

Statute Being Implemented: RCW 41.05.021, 41.05.160.

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: Not applicable.

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Stella Ng, 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.

May 3, 2021
Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 20-16-062, filed 7/28/20, effective 1/1/21)

WAC 182-12-300 Public employees benefits board (PEBB) wellness incentive program eligibility and procedural requirements. The 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.

WSR 21-10-076
PROPOSED RULES
HEALTH CARE AUTHORITY
(Public Employees Benefits Board)

[Admin #2021-01.06—Filed May 3, 2021, 8:54 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 21-04-108.

Title of Rule and Other Identifying Information: **The following sections in chapter 182-08 WAC are revised:** WAC 182-08-015 Definitions, 182-08-120 Employer contribution for the public employees benefits board (PEBB) benefits, 182-08-185 What are the requirements regarding premium surcharges?, 182-08-198 When may a subscriber change health plans?, 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 and 182-12-262 When may subscribers enroll or remove eligible dependents?

The following section in chapter 182-16 WAC is revised: WAC 182-16-020 Definitions.

Hearing Location(s): On June 8, 2021, at 10:00 a.m. In response to the coronavirus disease 2019 (COVID-19) public health emergency, the agency will not provide a physical location for this hearing. This promotes 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 attend the virtual public hearing, you must register at the following link https://attendee.gotowebinar.com/register/8620587191761803532, Webinar ID 384-227-715. After registering, you will receive a confirmation email containing the information about joining the webinar.

Date of Intended Adoption: Not sooner than June 9, 2021.

Submit Written Comments to: Health Care Authority (HCA) Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, by June 8, 2021.

Assistance for Persons with Disabilities: Contact Amber Lougheed, phone 360-725-1349, fax 360-586-9727, telecommunication[s] relay service 711, email amber.lougheed@hca.wa.gov, by May 21, 2021.

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. Make technical amendments:

- Amended WAC 182-08-185 to update a subsection reference in WAC 182-12-205.
- Amended WAC 182-08-198 to include and update federal citations for medicare advantage-prescription drug plans and to clarify special open enrollment opportunities only apply if the dependent is a tax dependent.
- Amended WAC 182-08-245 to clarify board members of school districts and educational service districts.
- Amended WAC 182-12-262 to update federal citation references and add language related to special open enrollment event when a subscriber's dependent enrolls in medicare or loses eligibility for medicare, and to clarify a subscriber must certify the state registered domestic partner or state registered domestic partner's child is a tax dependent.

2. Amend rules to improve the administration of the PEBB program:

- Amended WAC 182-08-015 and 182-12-109 to update the definitions of annual open enrollment, long-term disability insurance or LTD insurance, special open enrollment, supplemental coverage, and waive.
- Amended WAC 182-08-120 to change basic long-term disability insurance to employer-paid long-term disability insurance.
- Amended WAC 182-16-020 to update the definition of long-term disability insurance or LTD insurance, to remove the definition of disability insurance, and to amend the definition of file or filing to include delivery methods for filing an appeal.

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, 26 U.S.C. § 105, 106, and 152; and 42 C.F.R. § 406.24, 422.62(b), and 423.38(c).

Agency Comments or Recommendations, if any, as to Statutory Language, Implementation, Enforcement, and Fiscal Matters: Not applicable.

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Stella Ng, 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.

May 3, 2021
Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 20-16-062, filed 7/28/20, effective 1/1/21)

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~~)) (see definition of "waive" in this section). 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 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 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 (USE RRA), 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 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.

"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 gov-

ernment, 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 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~~)) employer-paid long-term disability insurance ((~~paid for by the employing agency and supplemental~~)) and employee-paid long-term disability insurance offered ((~~to and paid for by the employee~~)) by the PEBB program.

"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, 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~~)) (see definition of "waive" in this section). 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((~~,~~)) or 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 PEBB medical ((~~plan~~)) because the employee is enrolled in other employer-based group medical, a TRICARE plan, or medicare as allowed under WAC 182-12-128((~~, or is~~)). An employee on approved educational leave ((~~and~~)) who obtains another employer-based group health plan may waive enrollment as allowed under WAC 182-12-136. An employee may waive enrollment in PEBB medical to enroll in SEBB medical only if they are enrolled in SEBB dental and SEBB vision. An employee who waives enrollment in PEBB medical to enroll in SEBB medical also waives enrollment in PEBB dental.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-08-120 Employer contribution for the public employees benefits board (PEBB) benefits. The employer contribution must be used to provide public employees benefits board (PEBB) insurance coverage for the

basic life insurance benefit, basic accidental death and dismemberment insurance benefit (AD&D), the ((~~basic~~)) employer-paid long-term disability (LTD) insurance benefit, medical insurance, dental insurance, and to establish a reserve for any remaining balance. There is no employer contribution available for any other insurance coverage for employees employed by state agencies.

AMENDATORY SECTION (Amending WSR 20-16-062, filed 7/28/20, effective 1/1/21)

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 (7), 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 (a) of this 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 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 20-16-062, filed 7/28/20, effective 1/1/21)

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. Secs. 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. Secs. 422.62(b) and 423.38(c). The new 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.

Note: A subscriber may not change their health plan if their state registered domestic partner or state registered domestic partner's child is not a tax dependent.

(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 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 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 medical plan becomes unavailable due to the subscriber's or a subscriber's dependent's enrollment in medicare, the subscriber must select a new 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 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 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 20-16-062, filed 7/28/20, effective 1/1/21)

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 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 board members 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 20-16-062, filed 7/28/20, effective 1/1/21)

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 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~~)) (see definition of "waive" in this section). 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 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 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 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 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~~)) employer-paid long-term disability insurance ((~~paid for by the employing agency~~)) and ((~~supplemental~~)) employee-paid long-term disability insurance offered ((~~to and paid for by the employee~~)) by the PEBB program.

"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, 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.

"SEBB insurance coverage" means any 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~~)) (see definition of "waive" in this section). 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((~~,~~)) or 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 PEBB medical because the employee is enrolled in other employer-based group medical, a TRICARE plan, or medicare as allowed under WAC 182-12-128((~~, or is~~)). An employee on approved educational leave ((~~and~~)) who obtains another employer-based group health plan may waive enrollment as allowed under WAC 182-12-136. An employee may waive enrollment in PEBB medical to enroll in SEBB medical only if they are enrolled in SEBB dental and SEBB vision. An employee who waives enrollment in PEBB medical to enroll in SEBB medical also waives enrollment in PEBB dental.

AMENDATORY SECTION (Amending WSR 20-16-062, filed 7/28/20, effective 1/1/21)

WAC 182-12-262 When may subscribers enroll or remove eligible dependents? (1) **Enrolling dependents in public employees benefits board (PEBB) 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 the dependent's effective date will be as follows:

(i) PEBB health plan coverage will be the same as the subscriber's effective date;

(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;

(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 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;

(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 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 health plan coverage prospectively. PEBB 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. Secs. 422.62(b) and ((~~42 C.F.R. Sec.~~)) 423.38(c).

(i) PEBB 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) PEBB health plan coverage for an extended dependent or a dependent with a disability will begin the first day of the month following the later of the event date 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 health plan coverage will begin or end as follows:

• For the newly born child, PEBB health plan coverage will begin the date of birth;

• For a newly adopted child, PEBB 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 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;

(b) Any one of the following events may create a special open enrollment:

(i) Subscriber acquires a new dependent due to:

• Marriage or registering a state registered domestic partnership;

• Birth, adoption, or when a 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) 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);

(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;

(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 (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.

(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;

(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;

(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);

(viii) Subscriber or a subscriber's dependent 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;

(ix) Subscriber or a subscriber's dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from medicaid or CHIP;

(x) Subscriber's dependent enrolls in medicare, or loses eligibility for medicare.

(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.

Note: When enrolling a state registered domestic partner or a state registered domestic partner's child, a subscriber must certify that the state registered domestic partner or state registered domestic partner's child is a tax dependent on the required form; otherwise, the PEBB program will assume the state registered domestic partner or state registered domestic partner's child is not a tax dependent.

(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 child reaches age twenty-six or within the relevant time frame described in (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. Secs. 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 20-16-062, filed 7/28/20, effective 1/1/21)

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 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, 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-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. A document may be filed by one or more of the following:

• Personal delivery to the authority at Cherry Street Plaza, 626 8th Avenue S.E., Olympia, Washington 98501;

• First class, registered, or certified mail to the authority to the following mailing address:

Health Care Authority
Attn: PEBB Appeals Unit
P.O. Box 45504
Olympia, WA 98504-5504;

• Fax: 360-763-4709; or

• Submission online through the designated submission portal.

The identified methods are the exclusive methods for a document to be filed, and submission of documents by any other fashion to the authority shall not constitute filing unless agreed to in advance by the authority.

"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 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~~)) employer-paid long-term disability insurance ((~~paid for by the employing agency~~)) and ((~~supplemental~~)) employee-paid long-term disability insurance offered ((~~to and paid for by the employee~~)) by the PEBB program.

"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, 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.

WSR 21-10-077
PROPOSED RULES
STATE BOARD OF HEALTH
[Filed May 3, 2021, 10:28 a.m.]

Supplemental Notice to WSR 20-24-119.

Preproposal statement of inquiry was filed as WSR 18-24-016.

Title of Rule and Other Identifying Information: Chapter 246-680 WAC, Prenatal tests—Congenital and heritable disorders, the state board of health (board) is filing a supplemental notice to WSR 20-24-119 proposing additional amendments to rules to align the prenatal screening and diagnostic tests that are considered medically necessary and required to be included in benefits packages by certain payers with national standards of care and current best practices.

Hearing Location(s): On June 9, 2021, at 1:30 p.m. In response to the coronavirus disease 2019 (COVID-19) public health emergency, the 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. Board member, presenters, and staff will all participate remotely. The public may login using a computer or device, or call-in using a phone to listen to the meeting through the GoTo Webinar application. The public may submit verbal comments during the specified rules hearing segment. To access the meeting online and register https://attendee.gotowebinar.com/register/340060668939096335. You can also dial-in and listen/observe only using your phone +1 (914) 614-3221, Access Code 175-500-000.

Date of Intended Adoption: June 9, 2021.

Submit Written Comments to: Samantha Pskowski, P.O. Box 47990, Olympia, WA 98504-7990, email https://fortress.wa.gov/doh/policyreview, by May 26, 2021.

Assistance for Persons with Disabilities: Samantha Pskowski, phone 360-789-2358, TTY 711, email samantha.pskowski@sboh.wa.gov, by June 2, 2021.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The purpose of this proposal is to update the board's existing rules outlining prenatal screenings and diagnostic tests required to be covered by certain payers to align with current clinical standards and best practices. The board's rule was last updated in 2003, and since such time, new screenings and diagnostics have become available and standards of practice have been revised. This proposal would increase access to certain prenatal screening and diagnostic testing for pregnant individuals.

The board held a public hearing on January 13, 2021. The board determined it would continue its consideration of the proposal until its June 9, 2021, meeting in recognition of interested parties' significant comment regarding certain prenatal tests and requirements for pre- and postprocedure genetic counseling. As a result of public comments, the board has made the following changes to the proposed rule since it was filed in December 2020 as WSR 20-24-119: Requirements for documentation of genetic counseling for cell-free DNA testing, clarification that cytogenomic microarray testing should be targeted, clarification that certain tests do not require pre- and postprocedure genetic counseling, and other administrative changes.

Reasons Supporting Proposal: There have been many advances in prenatal screening over the years. These newer procedures offer better detection rates for birth defects or genetic conditions, as well as lower false positive rates. The purpose of the proposed rule is to continue to ensure equity for accessing prenatal screening and diagnostic services for pregnant individuals that choose them and to bring the rule into alignment with national standards of care and current best practices.

In 1988, the Washington state legislature passed legislation that: (1) Required health care providers treating pregnant individuals to inform them about the availability of prenatal screening and testing options (RCW 70.54.220); (2) required multiple payers to cover such services (RCW 48.21.244, 48.44.344 and 48.46.375); and (3) placed limitations on certain payers to ensure they did not cancel, reduce, or alter coverage provided solely based on results of a prenatal test (RCW 48.42.90). The board has the authority to establish standards in rule for screening and diagnostic procedures during pregnancy when those services are determined to be medically necessary. The regulations were written to eliminate the coercive and unethical practices of some payers who offered to cover the costs of prenatal screening and diagnostic procedures only if patients signed an agreement that they would terminate the pregnancy if an abnormality was found.

All pregnancies have a three to five percent risk for a birth defect and may be at an additional risk for genetic disorders. Prenatal tests are available to provide information about some of these risks and can help improve health outcomes. Prenatal screening and diagnostic testing can have a significant impact on pregnancies at risk for a genetic condition or birth defect by: (1) Enabling early diagnosis or preventative approaches to reduce the amount of resources needed for postnatal diagnosis of symptomatic children; (2) providing an opportunity to initiate appropriate health care services and interventions as soon as possible to improve the health of children and their families; and (3) informing pregnant individuals and their families about health risks to current and future pregnancies to empower them to make informed pregnancy related health decisions.

Statutory Authority for Adoption: RCW 43.20.050, 48.21.244, 48.44.344, 48.46.375, and 70.54.220.

Statute Being Implemented: RCW 70.54.220, 43.20.050, 48.44.344, 48.21.244, and 48.46.375.

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

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

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: Samantha Pskowski, 101 Israel Road S.E., Tumwater, WA, 98504-7990, 360-789-2358.

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 Samantha Pskowski, P.O. Box 47990, Olympia, WA 98504-7990, phone 360-789-2358, TTY 711, email samantha.pskowski@sboh.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 19.85.025(4).

Explanation of exemptions: It has been determined that there are no small businesses in the direct health and medical insurance carriers industry and therefore this proposal is exempt.

May 3, 2021
Michelle A. Davis
Executive Director

AMENDATORY SECTION (Amending WSR 03-11-031, filed 5/15/03, effective 6/15/03)

WAC 246-680-010 Definitions. ((~~For the purpose of this chapter, the following definitions apply:~~

~~(1) "Department" means the Washington state department of health.~~

~~(2) "Health care providers" means persons licensed or certified by the state of Washington under Title 18 RCW to provide prenatal care or to practice medicine and qualified genetic counselors.~~

~~(3) "Prenatal carrier testing" means a procedure to remove blood or other tissue from one or both parents in order to perform laboratory analysis to establish chromosome constitution or genetic carrier status of the parents.~~

~~(4)~~)) The definitions in this section apply throughout this chapter unless the context clearly requires otherwise:

(1) "Amniocentesis" means a procedure to remove a small amount of amniotic fluid from the uterus of a pregnant person in order to perform one or more of the following laboratory tests:

(a) Measure the level of alpha-fetoprotein;

(b) Measure the level of acetylcholinesterase;

(c) Cytogenetic studies on fetal cells including chromosome analysis, cytogenomic microarray analysis (CMA), and fluorescent in-situ hybridization (FISH);

(d) Biochemical studies on fetal cells or amniotic fluid;

(e) Deoxyribonucleic acid (DNA) studies on fetal cells for single gene disorders or fetal genotyping for isoimmunization studies; and

(f) Infectious disease studies.

(2) "Carrier screening" means a procedure to remove blood or other tissue from one or both parents in order to perform laboratory analysis to establish chromosome constitution or recessive or X-linked genetic carrier status of the parents.

(3) "Chorionic villus sampling" means a procedure to remove a small number of cells from the developing placenta, in order to perform one or more of the following laboratory tests:

(a) Cytogenetic studies on fetal cells including chromosome analysis, cytogenomic microarray analysis (CMA), and fluorescent in-situ hybridization (FISH);

(b) Biochemical studies on placental cells; and

(c) DNA studies on placental cells for single gene disorders.

(4) "Hepatitis B surface antigen (HBsAg) screening" means a procedure involving obtaining blood from a pregnant person to test for maternal hepatitis B infection.

(5) "Maternal serum marker screening" means a procedure involving obtaining blood from a pregnant person in order to measure through laboratory tests the level of certain products that are associated with increased risks to the fetus or pregnancy such as alpha-fetoprotein, unconjugated estriol, human gonadotropin, inhibin, or PAPP-A.

(6) "Percutaneous umbilical blood sampling" means a procedure to obtain blood from the fetus, in order to perform one or more of the following laboratory tests:

(a) Cytogenetic studies on fetal cells including chromosome analysis, cytogenomic microarray analysis (CMA), and fluorescent in-situ hybridization (FISH);

(b) Viral titer studies;

(c) Fetal blood typing for isoimmunization studies;

(d) Prenatal diagnostic tests for hematological disorders;

(e) DNA studies on fetal cells for single gene disorders; and

(f) Biochemical studies on fetal blood.

(7) "Postprocedure genetic counseling" means individual counseling that may be part of another procedure, or service involving a health care provider and a pregnant person with or without other family members, to discuss the results of the prenatal tests done, any further testing or procedures available or referrals for further consultation or counseling.

(8) "Prenatal cell free DNA screening," sometimes called noninvasive prenatal screening, means drawing blood from the pregnant person to perform laboratory analysis on the cell free DNA circulating in the maternal blood stream.

(9) "Prenatal test" means any test or procedure to ((~~predict~~)) screen for or diagnose congenital or heritable disorders ((~~that may harm or endanger the health, safety, or welfare of members of the public if improperly utilized and includes preprocedure and postprocedure genetic counseling, laboratory tests, and procedures as follows:~~

~~(a) Maternal serum marker screening is a procedure involving obtaining blood from a pregnant woman during the fifteenth to twenty-second week of gestation, in order to measure through laboratory tests the level of certain analytes that are associated with increased risks to the fetus or pregnancy such as alpha-fetoprotein, unconjugated estriol, human gonadotropin, inhibin, and/or PAPP-A.~~

~~(b) Maternal hepatitis B surface antigen (HBsAg) screening is a procedure involving obtaining blood from a pregnant woman during the first trimester of pregnancy to test for maternal hepatitis B infection. HBsAg screening should be repeated during the last trimester of pregnancy if a woman is at high risk for hepatitis B infection.~~

~~(c) Group B strep screening per vaginorectal culture at 35-37 weeks gestation is used to screen pregnant women for Group B strep colonization. The swab culture specimen must be grown in selective broth media.~~

~~(d) Amniocentesis is a procedure performed after fourteen weeks of gestation to remove a small amount of amniotic fluid from the uterus of a pregnant woman, in order to perform one or more of the following laboratory tests:~~

~~(i) Measure the level of alpha-fetoprotein;~~

~~(ii) Measure the level of acetylcholinesterase;~~

~~(iii) Cytogenetic studies on fetal cells including fluorescent in-situ hybridization (FISH) if indicated;~~

~~(iv) Biochemical studies on fetal cells or amniotic fluid;~~

~~(v) Deoxyribonucleic Acid (DNA) studies on fetal cells including fetal genotyping for isoimmunization studies; and~~

~~(vi) Infectious disease studies.~~

~~(e) Chorionic villus sampling is a procedure performed from ten to twelve weeks of gestation to remove a small amount of cells from the developing placenta, in order to perform one or more of the following laboratory tests:~~

~~(i) Cytogenetic studies on fetal cells including fluorescent in-situ hybridization (FISH) if indicated;~~

~~(ii) Biochemical studies on fetal cells; and~~

~~(iii) DNA studies on fetal cells.~~

~~(f) Percutaneous umbilical cord blood sampling is a procedure performed typically after fifteen weeks of gestation to obtain blood from the fetus, in order to perform one or more of the following laboratory tests:~~

~~(i) Cytogenetic studies including fluorescent in-situ hybridization (FISH) if indicated;~~

~~(ii) Viral titer studies;~~

~~(iii) Fetal blood typing for isoimmunization studies;~~

~~(iv) Prenatal diagnostic tests for hematological disorders;~~

~~(v) DNA studies on fetal cells;~~

~~(vi) Biochemical studies on fetal blood.~~

~~(g)~~)) of a fetus.

(10) "Prenatal ultrasonography ((~~is~~))" means a procedure ((~~performed at any time during pregnancy~~)) resulting in visualization of the uterus, the placenta, the fetus, and internal structures through use of sound waves.

(((~~(h)~~))) (11) "Preprocedure genetic counseling" means individual counseling((~~, which~~)) that may be part of another procedure, or service, involving a health care provider ((~~or a qualified genetic counselor under the direction of a physician,~~)) and a pregnant ((~~woman~~)) person with or without other family members, to assess and identify increased risks for congenital abnormalities or pregnancy complications, offer specific carrier screening or diagnostic tests, discuss the purposes, risks, accuracy, and limitations of a prenatal testing procedure, aid in decision making and to assist, when necessary, in obtaining the desired testing or procedure.

(((~~(i) "Postprocedure genetic counseling" means, when test results are available, individual counseling, which may be part of another procedure or service, involving a health care provider or a qualified genetic counselor under the direction of a physician and a pregnant woman with or without other family members, to discuss the results of the prenatal tests done, any further testing or procedures available and/or referrals for further consultation or counseling.~~

~~(j) "Qualified genetic counselor" means an individual eligible for certification or certified as defined by the American Board of Medical Genetics, Inc., or the American Board of Genetic Counseling.~~))

AMENDATORY SECTION (Amending WSR 03-11-031, filed 5/15/03, effective 6/15/03)

WAC 246-680-020 Board of health standards for screening and diagnostic tests during pregnancy. (1) For the purpose of RCW 48.21.244, 48.44.344, and 48.46.375, the following are standards of medical necessity for insurers, health care service contractors, and health maintenance organizations to use when authorizing requests or claims for prenatal screening ((~~and/or~~)) or diagnosis without the requirement of a case-by-case determination:

(a) Hepatitis B surface antigen (HBsAg) screening for all pregnant persons during the first trimester of pregnancy and the last trimester of pregnancy if the person is at high risk for hepatitis B infection.

(b) Group B strep screening through prenatal vaginorectal cultures at thirty-five to thirty-seven weeks of gestation. Pregnant persons who are currently colonized with Group B strep, or who have unknown Group B strep status should receive intrapartum treatment in accordance with the current standard of practice in order to reduce risk to the newborn.

(2) For the purpose of RCW 48.21.244, 48.44.344, and 48.46.375, the following are standards of medical necessity for insurers, health care service contractors, and health maintenance organizations to use when authorizing requests or claims for prenatal screening or diagnosis without the requirement of a case-by-case determination and including preprocedure and postprocedure genetic counseling:

(a) Maternal serum marker screening for all pregnant ((~~women~~)) persons at the beginning of prenatal care if initiated before the ((~~twentieth~~)) twenty-second completed week of gestation.

(b) ((~~Maternal hepatitis B surface antigen (HBsAg) screening for all pregnant women during the first trimester of pregnancy and the last trimester of pregnancy if the woman is at high risk for hepatitis B infection.~~

~~(c) Information about Group B strep should be provided to all pregnant women, including the risk to the newborn, if the woman is identified through screening as potentially colonized with Group B strep. Screening is done through prenatal vaginorectal cultures, although specific clinical indicators may preclude screening. Pregnant women who are currently colonized with Group B strep, or who have unknown Group B strep status should receive intrapartum treatment in accordance with the current standard of practice in order to reduce risk to the newborn.~~

~~(d)~~)) Prenatal ultrasonography:

(i) During the first trimester to establish viability, gestational age, and determine if singleton or multiple births; and

(ii) During second trimester for fetal morphology.

(c) Additional prenatal ultrasonography can be done at any time during a pregnancy if one or more of the following criteria are met:

(i) A ((~~woman~~)) person is undergoing amniocentesis, chorionic villus sampling, ((~~or~~)) percutaneous umbilical ((~~cord~~)) blood sampling, or fetal tissue biopsy;

(ii) The results of a maternal serum marker screening or prenatal cell free DNA test indicate an increased risk to the fetus or pregnancy;

(iii) ((~~A woman or the biological father of the fetus has a personal or family history of a congenital abnormality detectable by prenatal ultrasound;~~

~~(iv)~~)) There is an increased risk of a congenital abnormality ((~~is present~~)) due to:

(A) An environmental exposure ((~~including maternal exposure to alcohol; or~~

~~(v)~~));

(B) A medical evaluation ((~~indicates~~)) indicating the possibility of polyhydramnios ((~~or~~)), oligohydramnios, or poor or accelerated fetal growth; or

(C) A personal or family history of a congenital abnormality that is potentially detectable by prenatal ultrasound.

(((~~(c)~~))) (d) Amniocentesis ((~~if one or more of the following criteria are met:~~

~~(i) A woman is thirty-five years of age or older at the time of delivery;~~

~~(ii) A woman or the biologic father of the fetus has a previous child or fetus with a chromosomal abnormality or other prenatally diagnosable disorder;~~

~~(iii) A woman or the biologic father of the fetus has a family history that includes birth defects or developmental delays;~~

~~(iv) A woman or the biologic father of the fetus is a carrier of a chromosomal rearrangement;~~

~~(v) A woman and/or the biologic father of the fetus are carriers of, or affected with, a prenatally diagnosable inherited disorder;~~

~~(vi) The results of a maternal serum marker screening test indicate an increased risk to the pregnancy or fetus;~~

~~(vii) A woman has a documented history of three or more miscarriages of unknown cause when circumstances prevent parental chromosomal testing;~~

~~(viii) There is an ultrasound diagnosis of fetal anomaly;~~

~~(ix) A medical evaluation indicates an increased risk of fetal infection;~~

~~(x) Fetal blood studies are indicated for isoimmunization studies or therapy.~~

~~(f)~~)) after fourteen weeks of gestation.

(e) Chorionic villus sampling ((~~with preprocedure and postprocedure genetic counseling if one or more of the following criteria are met:~~

~~(i) A woman is thirty-five years of age or older at the time of delivery;~~

~~(ii) A woman or the biologic father of the fetus has a previous child or fetus with a chromosomal abnormality or other prenatally diagnosable inherited disorder;~~

~~(iii) A woman or the biologic father of the fetus is a carrier of a chromosomal rearrangement;~~

~~(iv) A woman or the biologic father of the fetus is a carrier of, or affected with, a prenatally diagnosable inherited disorder;~~

~~(v) A woman has a documented history of three or more miscarriages of unknown cause when circumstances prevent parental chromosomal testing; or~~

~~(vi) Fetal genotyping is indicated to determine risks for isoimmunization.~~

~~(g)~~)) between ten and fourteen weeks of gestation.

(f) Fetal diagnostic testing including:

(i) Cytogenetic studies on fetal cells including chromosome analysis, targeted cytogenomic microarray analysis (CMA), and fluorescent in-situ hybridization (FISH) ((~~if a medical evaluation indicates a rapid or specific submicroscopic chromosomal diagnosis is required to predict the prognosis for the fetus~~)) for any person undergoing amniocentesis or chorionic villus sampling; and

(ii) DNA testing, biochemical testing, or testing for infectious diseases if medically indicated because of an abnormal ultrasound finding, intrauterine fetal demise, or known family history; and

(iii) Cytogenomic microarray analysis in the case of recurrent intrauterine fetal demise.

(g) Prenatal cell free DNA testing performed after nine weeks of gestation for the detection of aneuploidy including trisomy 21, 18, 13, or the sex chromosomes if the following criteria are met:

(i) There is documentation of preprocedure genetic counseling;

(ii) There is documentation of a scheduled appointment for postprocedure genetic counseling; and

(iii) Testing the sex chromosomes is not solely for the purposes of determining the sex of the fetus.

(h) Carrier screening at any time during the pregnancy for:

(i) Recessive or X-linked conditions if indicated by a positive family history; and

(ii) Any of the following conditions irrespective of family history:

(A) Alpha-thalassemia (HBA1/HBA2);

(B) Beta-thalassemia;

(C) Bloom syndrome;

(D) Canavan disease;

(E) Cystic fibrosis;

(F) Familial dysautonomia (IKBKAP);

(G) Fanconi anemia type C (FANCC);

(H) Gaucher disease (GBA);

(I) Mucolipidosis IV (MCOLN1); or

(J) Niemann-Pick disease (SMPD1);

(K) Sickle cell disease;

(L) Spinal muscular atrophy (SMN1);

(M) Tay-Sachs disease (HEXA);

(N) Fragile-X Syndrome.

(iii) Carrier screening under (h)(i) and (ii) of this subsection may be limited to once per lifetime.

(i) Molecular genetic or cytogenetic testing of parents to allow for definitive fetal testing, or parental testing to better inform results that are suggestive of, but do not identify a unifying diagnosis and when the results of the parental testing will be used to guide treatment, reproductive decisions, or care planning that would not otherwise be made.

(((~~(2)~~))) (3) The ((~~board recommends the~~)) following ((~~additional~~)) procedures ((~~for use by insurers, health service contractors, and health maintenance organizations in determining medical necessity on a case-by-case basis~~)) are for use by insurers, health service contractors, and health maintenance organizations in determining medical necessity on a case-by-case basis to use when authorizing requests for claims for prenatal screening and diagnosis:

(a) Percutaneous umbilical cord blood sampling ((~~with preprocedure and postprocedure genetic counseling~~)) after fifteen weeks of gestation if one or more of the following criteria are met:

(i) A medical evaluation indicates rapid or specific submicroscopic chromosomal diagnosis or DNA diagnosis is required to predict prognosis for the fetus;

(ii) A medical evaluation indicates the possibility of a prenatally diagnosable fetal infection;

(iii) Fetal blood studies are medically indicated for isoimmunization studies or therapy;

(iv) Fetal blood is the only means to provide biochemical genetic diagnosis;

(v) Prenatal diagnosis of a hematological disorder is medically indicated.

(b) Prenatal tissue biopsy if the nature of the disorder in question indicates that fetal liver, skin, or other tissue biopsy is the only means to provide biochemical genetic diagnosis to protect the health of the ((~~mother~~)) pregnant person or predict the prognosis of the fetus.

(c) Cytogenomic microarray analysis (CMA) if medically indicated because of an abnormal ultrasound finding or known family history.

WSR 21-10-087
PROPOSED RULES
DEPARTMENT OF HEALTH

[Filed May 3, 2021, 12:34 p.m.]

Original Notice.

Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1).

Title of Rule and Other Identifying Information: WAC 246-282-005 Sanitary control of shellfish minimum performance standards, the department of health (department) is amending WAC 246-282-005 which references the 2017 version of the National Shellfish Sanitation Program (NSSP) Guide for the Control of Molluscan Shellfish (guide). The rule making is necessary to update the publication date of the NSSP guide adopted by reference in the rule from 2017 to the most recently adopted 2019 version.

Hearing Location(s): On June 10, 2021, at 1:00 p.m. In response to the coronavirus disease 2019 (COVID-19) public health emergency, the department 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. Please register at https://attendee.gotowebinar.com/register/6909954906774766608. After registering, you will receive a confirmation email containing information about joining the webinar. Participants can use their telephone or computer mic and speakers (VoIP) United States +1 (631) 992-3221.

Date of Intended Adoption: June 17, 2021.

Submit Written Comments to: Nina Helpling, Washington State Department of Health (DOH), Division of Environmental Health, P.O. Box 47820, Olympia, WA 98504-7820, email https://fortress.wa.gov/doh/policyreview, by June 10, 2021.

Assistance for Persons with Disabilities: Contact Nina Helpling, phone 360-236-3065, TTY 711, email nina.helpling@doh.wa.gov, by June 3, 2021.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposed amendments will update the reference to the NSSP guide to assure [ensure] that the most current health and safety requirements are in rule as required by the statute. The United States Food and Drug Administration (FDA) requires all shellfish-producing states to follow the most current version of the NSSP guide in order to place molluscan shellfish into interstate commerce. The rule currently references the 2017 NSSP guide, leaving the current rules out of date. The proposed rule updates the reference to the 2019 version of the NSSP guide.

Reasons Supporting Proposal: The FDA oversees a cooperative program between the shellfish-producing states and the shellfish industry for the production and processing of shellfish consistent with the NSSP guide. The FDA evaluates each state's shellfish sanitation control program to ensure compliance with the NSSP guide. Therefore, an update of WAC 246-282-005 is needed so that Washington state remains compliant with the NSSP guide and the molluscan shellfish products from Washington can continue to be placed into interstate commerce.

Statutory Authority for Adoption: RCW 69.30.030.

Statute Being Implemented: RCW 69.30.030.

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

Name of Proponent: DOH, governmental.

Name of Agency Personnel Responsible for Drafting: Nina Helpling, 111 Israel Road S.E., Tumwater, WA 98501, 360-236-3065; Implementation and Enforcement: Scott Berbells, 111 Israel Road S.E., Tumwater, WA 98501, 360-236-3324.

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. The department did not complete a cost-benefit analysis under RCW 34.05.328. RCW 34.05.328 (5)(b)(iii) exempts rules that adopt or incorporate by reference without material change federal statutes or regulations, Washington state law, the rules of other Washington state agencies, or national consensus codes that generally establish industry standards.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.061 because this rule making is being adopted solely to conform and/or comply with federal statute or regulations. Citation of the specific federal statute or regulation and description of the consequences to the state if the rule is not adopted: RCW 69.30.030(2) mandates the state board of health to consider the most recent version of the national shellfish sanitation program model ordinance, adopted by the interstate shellfish sanitation conference, when adopting rules. In order to remain compliant with the FDA requirements to place molluscan shellfish into interstate commerce, the department must adopt rules that are at least as stringent as the most recent version of the NSSP

guide. The proposed amendments are needed to remain compliant with the 2019 NSSP guide.

Is exempt under RCW 19.85.025(3) as the rules are adopting or incorporating by reference without material change federal statutes or regulations, Washington state statutes, rules of other Washington state agencies, shoreline master programs other than those programs governing shorelines of statewide significance, or, as referenced by Washington state law, national consensus codes that generally establish industry standards, if the material adopted or incorporated regulates the same subject matter and conduct as the adopting or incorporating rule.

April 21, 2021
Lauren Jenks
Assistant Secretary

AMENDATORY SECTION (Amending WSR 19-14-094, filed 7/1/19, effective 8/1/19)

WAC 246-282-005 Minimum performance standards. (1) Any person engaged in a shellfish operation or possessing a commercial quantity of shellfish or any quantity of shellfish for sale for human consumption must comply with and is subject to:

(a) The requirements of the U.S. Food and Drug Administration National Shellfish Sanitation Program (NSSP), Guide for the Control of Molluscan Shellfish ((~~(2017)~~)) (2019) (copies available through the U.S. Food and Drug Administration, Shellfish Sanitation Branch, and the Washington state department of health, office of shellfish and water protection);

(b) The provisions of 21 Code of Federal Regulations (C.F.R.), Part 123 - Fish and Fishery Products, adopted December 18, 1995, by the United States Food and Drug Administration, regarding Hazard Analysis Critical Control Point (HACCP) plans (copies available through the U.S. Food and Drug Administration, Office of Seafood, and the Washington state department of health, office of food safety and shellfish programs); and

(c) All other provisions of this chapter.

(2) If a requirement of the NSSP Model Ordinance or a provision of 21 C.F.R., Part 123, is inconsistent with a provision otherwise established under this chapter or other state law or rule, then the more stringent provision, as determined by the department, will apply.

WSR 21-10-090
PROPOSED RULES
BOARD OF INDUSTRIAL INSURANCE APPEALS

[Filed May 3, 2021, 4:39 p.m.]

Original Notice.

Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1).

Title of Rule and Other Identifying Information: Chapter 263-12 WAC, Practice and procedure (before the board of industrial insurance appeals).

Hearing Location(s): On July 7, 2021, at 9:30 a.m., virtual or telephonic hearing only. Please use your computer or mobile app to join on Zoom https://zoom.us/j/93778043147, or call in (audio only) 253-215-8782, Meeting ID 937 7804 3147.

Date of Intended Adoption: July 8, 2021.

Submit Written Comments to: David Threedy, P.O. Box 42401, Olympia, WA, email Dave.Threedy@biia.wa.gov, fax 855-586-5611, by 5 p.m., on July 7, 2021.

Assistance for Persons with Disabilities: Contact Robert Krabill, phone 360-753-6823, fax 885-586-5611, TTY 800-833-6388, website www.biia.wa.gov, by June 28, 2021.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Housekeeping: WAC 263-12-015, 263-12-01501, 263-12-020, 263-12-045, 263-12-118, 263-12-170, 263-12-195. The working job title of the executive secretary has been changed to chief legal officer. These amendments will align our rules with this change.

WAC 263-12-020, the rule with regard to who may represent a party is updated to reflect that a corporate officer of an employer may represent the employer.

WAC 263-12-045, amendment to the existing rule on appointing pro tem industrial appeal judges to reflect pro tem judges can be appointed to respond to increases in workloads in addition to the reasons already stated in the rule.

WAC 263-12-052, change the name to claim resolution settlement agreements and relax the requirements to include certain statements in the agreement so long as the agreement otherwise reflects conformance with the various requirements of the statute. Address the disposition of active appeals by stay and dismissal upon the expiration of the revocation period unless other disposition of the appeal is specified by the agreement.

WAC 263-12-053, a new rule permitting amendments of agreements without the need to refile.

WAC 263-12-091, amendments regarding filing of affidavits of prejudice in order to remove reference to RCW 4.12.050 concerning disqualification and to allow the filing of an affidavit of prejudice if an appeal is assigned to a new industrial appeals judge for the writing of the proposed decision and order.

WAC 263-12-097, clarifies that the recent civil rule changes to use of team interpreters does not apply to proceedings at the board.

WAC 263-12-117, removes the requirement that a paper copy of the deposition transcript be filed in addition to the electronic copy.

Reasons Supporting Proposal: WAC 263-12-015, 263-12-01501, 263-12-020, 263-12-045, 263-12-118, 263-12-170, 263-12-195. The working job title of the executive secretary has been changed to chief legal officer. The changes are necessary to align various rule requirements with this change of job title.

WAC 263-12-020, rule is updated to allow corporate officers to represent the corporate employer.

WAC 263-12-045, allows appointment of pro tem judges if needed to address fluctuations in workload.

WAC 263-12-052, in response to recent legislation, changes the name to claim resolution settlement agreements. The amendments also relax the requirements to include certain statements in the agreement so long as the agreement otherwise reflects conformance with the various requirements of the statute. Address the disposition of active appeals by stay and dismissal upon the expiration of the revocation period unless other disposition of the appeal is specified by the agreement.

WAC 263-12-053, allows parties to amend agreements quickly saving time and expense of having to refile.

WAC 263-12-091, needed to update requirements of filing of affidavits of prejudice in order to remove reference to RCW 4.12.050 concerning disqualification and to allow the filing of an affidavit of prejudice if an appeal is assigned to a new industrial appeals judge for the writing of the proposed decision and order.

WAC 263-12-097, clarifies that the recent civil rule changes regarding use of team interpreters does not apply to proceedings at the board.

WAC 263-12-117, removes the requirement that a paper copy of the deposition transcript be filed in addition to the electronic copy. Paper copies are no longer needed due to electronic appeal record.

Statutory Authority for Adoption: RCW 51.52.020.

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

Name of Proponent: Board of industrial insurance appeals, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: David E. Threedy, Olympia, 360-753-6823.

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. These are procedural rules relating to procedures, practices, or requirements relating to agency rules. There are no significant legislative rules proposed.

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 only correct typographical errors, make address or name changes, or clarify language of a rule without changing its effect; and rules adopt, amend, or repeal a procedure, practice, or requirement relating to agency hearings; or a filing or related process requirement for applying to an agency for a license or permit.

April 27, 2021
David E. Threedy
Executive Secretary

AMENDATORY SECTION (Amending WSR 98-20-109, filed 10/7/98, effective 11/7/98)

WAC 263-12-015 Administration and organization. (1) **Composition of the board.** The board is an independent agency of the state of Washington composed of three members appointed by the governor. One member is a representative of workers, one member is a representative of employers, and the chairperson, who must be an active member of the Washington State Bar, is the representative of the public.

(2) **Location of the board.** The headquarters, and principal office of the board, is located at 2430 Chandler Ct. S.W., P.O. Box 42401, in Olympia, Washington 98504-2401.

(3) **Customary office hours.** The customary office hours of the board shall be from 8 a.m. to 5 p.m., Monday through Friday, excluding legal holidays.

(4) **Formal board meetings.** The board shall meet in formal session at its headquarters in Olympia, Washington at 9 a.m. on the first Tuesday of each month, and at such other times and places as the board may deem necessary, subject to 24-hour notice as required by law.

(5) **Staff organization.**

(a) The board's headquarters in Olympia is staffed with executive, administrative and clerical personnel.

(b) The board has a staff of industrial appeals judges who travel throughout the state in the performance of their duties and who have their offices in Olympia and in other areas of the state as is deemed necessary for efficient and cost effective handling of agency business.

(c) The office of the ((~~executive secretary~~)) chief legal officer of the board is located at the headquarters and principal office of the board.

AMENDATORY SECTION (Amending WSR 18-24-123, filed 12/5/18, effective 1/5/19)

WAC 263-12-01501 Communications and filing with the board. (1) **Where to file communications with the board.** Except as provided elsewhere in this section all written communications shall be filed with the board at its headquarters in Olympia, Washington. With written permission of the industrial appeals judge assigned to an appeal, depositions, witness confirmations, motions (other than motions for stay filed pursuant to RCW 51.52.050), briefs, stipulations, agreements, and general correspondence may be filed in the appropriate regional board facilities located in Tacoma, Spokane, or Seattle.

(2) **Methods of filing.** Unless otherwise provided by statute or these rules any written communication may be filed with the board by using one of four methods: Personally, by mail, by telephone facsimile, or by electronic filing. Failure of a party to comply with the filing methods selected by the party for use under this section, or as otherwise set forth in these rules or statute for filing written communications may prevent consideration of a document.

(a) **Filing personally.** The filing of a written communication with the board personally is accomplished by delivering the written communication to an employee of the board at the board's headquarters in Olympia during customary office hours.

(b) **Filing by mail.** The filing of a written communication with the board is accomplished by mail when the written communication is deposited in the United States mail, properly addressed to the board's headquarters in Olympia and with postage prepaid. Where a statute or rule imposes a time

limitation for filing the written communication, the party filing the same should include a certification demonstrating the date filing was perfected as provided under this subsection. Unless evidence is presented to the contrary, the date of the United States postal service postmark shall be presumed to be the date the written communication was mailed to the board.

(c) **Filing by telephone facsimile.**

(i) The filing of a written communication with the board by telephone facsimile is accomplished when a legible copy of the written communication is reproduced on the board's telephone facsimile equipment during the board's customary office hours. All facsimile communications must be filed with the board via fax numbers listed on the board's web site.

(ii) The hours of staffing of the board's telephone facsimile equipment are the board's customary office hours. Documents sent by facsimile communication comments outside of the board's customary office hours will be deemed filed on the board's next business day.

(iii) Any written communication filed with the board by telephone facsimile should be preceded by a cover page identifying the party making the transmission, listing the address, telephone and telephone facsimile number of such party, referencing the appeal to which the written communication relates, and indicating the date of, and the total number of pages included in, such transmission. A separate transmission must be used for each appeal. Transmissions containing more than one docket number will be rejected and filing will not be accomplished, unless the multiple docket numbers have been previously consolidated by the board.

(iv) The party attempting to file a written communication by telephone facsimile bears the risk that the written communication will not be received or legibly printed on the board's telephone facsimile equipment due to error in the operation or failure of the equipment being utilized by either the party or the board.

(v) The board may require a party to file an original of any document previously filed by telephone facsimile.

(d) **Electronic filing.** Electronic filing is accomplished by using the electronic filing link on the board's web site. Communication sent by email will not constitute or accomplish filing. Communication filed using the board's web site outside of the board's customary office hours will be deemed filed on the board's next business day. A separate transmission must be used for each appeal. Transmissions containing more than one docket number will be rejected and filing will not be accomplished, unless the multiple docket numbers have been previously consolidated by the board.

(3) **Electronic filing of a notice of appeal.** A notice of appeal may be filed electronically when using the appropriate form for electronic filing of appeals as provided on the board's web site. An electronic notice of appeal is filed when it is received by the board's designated computer during the board's customary office hours pursuant to WAC 263-12-015. Appeals received via the board's web site outside of the board's customary office hours will be deemed filed on the board's next business day. The board will issue confirmation to the filing party that an electronic notice of appeal has been received. The board may reject a notice of appeal that fails to comply with the board's filing requirements. The board will notify the filing party of the rejection.

(4) **Electronic filing of application for approval of claim resolution structured settlement agreement.** An application for approval of claim resolution structured settlement agreement must be filed electronically using the form for electronic filing of applications for approval of claim resolution structured settlement agreement as provided on the board's web site. An electronic application for approval of claim resolution structured settlement agreement is filed when received by the board's designated computer during the board's customary office hours pursuant to WAC 263-12-015. Applications received by the board via the board's web site outside of the board's customary office hours will be deemed filed on the board's next business day. The board will issue confirmation to the filing party that an electronic application for approval of claim resolution structured settlement agreement has been received. An electronic copy of the signed agreement for claim resolution structured settlement agreement must be submitted as an attachment to the application for approval. The board will reject an application for approval of claim resolution structured settlement agreement that fails to comply with the board's filing requirements. The board will notify the filing party of the rejection.

(5) **Sending written communication.** All correspondence or written communication filed with the board pertaining to a particular case, before the entry of a proposed decision and order, should be sent to the attention of the industrial appeals judge assigned to the case. Interlocutory appeals should be sent to the attention of the chief industrial appeals judge. In all other instances, written communications shall be directed to the ((~~executive secretary~~)) chief legal officer of the board.

(6) **Form requirements.** Any written communications with the board concerning an appeal should reference the docket number assigned by the board to the appeal, if known. Copies of any written communications filed with the board shall be served on all other parties or their representatives of record, and the original shall demonstrate compliance with the requirement to serve all parties. All written communications with the board shall be on paper 8 1/2" x 11" in size.

AMENDATORY SECTION (Amending WSR 16-24-054, filed 12/2/16, effective 1/2/17)

WAC 263-12-020 Appearances of parties before the board. (1) **Who may appear?** Any party to any appeal may appear before the board at any conference or hearing held in such appeal, either on the party's own behalf or by a representative as described in subsections (3) and (4) of this section.

(2) **Who must obtain approval prior to representing a party?** A person who is disbarred, resigns in lieu of discipline, or is presently suspended from the practice of law in any jurisdiction, or has previously been denied admission to the bar in any jurisdiction for reasons other than failure to pass a bar examination, shall not represent a party without the prior approval of the board. A written petition for approval shall be filed sixty calendar days prior to any event for which the person seeks to appear as a representative. The board may deny any petition that fails to demonstrate competence, moral character, or fitness.

(3) **Who may represent a party?**

(a) A worker or beneficiary may be represented by:

(i) An attorney at law with membership in good standing in the Washington state bar association or a paralegal supervised by an attorney at law with membership in good standing in the Washington state bar association.

(ii) An attorney at law with membership in good standing in the highest court of any other state or the District of Columbia.

(iii) A lay representative so long as the person does not charge a fee, is not otherwise compensated for the representation except as provided in (a)(iv) of this subsection, and files a declaration or affidavit with the board certifying compliance with this rule. The industrial appeals judge may alternatively permit this certification to be made under oath and reflected in a transcript or report of proceeding.

(iv) A lay representative employed by the worker's labor union whose duties include handling industrial insurance matters for the union, provided the person files a declaration or affidavit with the board certifying this status. The industrial appeals judge may alternatively permit this certification to be made under oath and reflected in a transcript or report of proceeding.

(v) Any lay representative seeking to represent a worker or beneficiary who has not provided the certification required under (a)(iii) and (iv) of this subsection will be excluded from serving as a worker's or beneficiary's representative.

(b) An employer or retrospective rating group may be represented by:

(i) An attorney at law with membership in good standing in the Washington state bar association or a paralegal supervised by an attorney at law with membership in good standing in the Washington state bar association.

(ii) An attorney at law with membership in good standing in the highest court of any other state or the District of Columbia.

(iii) A lay representative who is a corporate officer or an employee of the employer or retrospective rating group.

(iv) A firm that contracts with the employer or retrospective rating group to handle matters pertaining to industrial insurance.

(c) The department of labor and industries may be represented by:

(i) An attorney employed as assistant attorney general or appointed as a special assistant attorney general.

(ii) A paralegal supervised by an assistant attorney general or special assistant attorney general.

(iii) An employee of the department of labor and industries designated by the director, or his or her designee, in a claim resolution structured settlement agreement under RCW 51.04.063.

(d) A licensed legal intern may represent any party consistent with Washington state admission to practice rule 9(e).

(4) **Appeals under the Washington Industrial Safety and Health Act.**

(a) In an appeal by an employee or employee representative under the Washington Industrial Safety and Health Act, the cited employer may enter an appearance as prescribed in subsection (7) of this section and will be deemed a party to the appeal.

(b) In an appeal by an employer, under the Washington Industrial Safety and Health Act, an employee or employee representative may enter an appearance as prescribed in subsection (7) of this section and will be deemed a party to the appeal.

(c) A lay representative appearing on behalf of an employee or an employee representative in an appeal under the Washington Industrial Safety and Health Act is not subject to the compensation restrictions of subsection (3) of this section.

(5) **May a self-represented party be accompanied by another person?** Where the party appears representing himself or herself, he or she may be accompanied, both at conference and at hearing, by a lay person of his or her choosing who shall be permitted to accompany the party into the conference or hearing room and with whom he or she can confer during such procedures. If the lay person is also a witness to the proceeding, the industrial appeals judge may exclude the lay person from the proceeding as provided by Evidence Rule 615.

(6) **Assistance by the industrial appeals judge.** Although the industrial appeals judge may not advocate for either party, all parties who appear either at conferences or hearings are entitled to the assistance of the industrial appeals judge presiding over the proceeding. Such assistance shall be given in a fair and impartial manner consistent with the industrial appeals judge's responsibilities to the end that all parties are informed of the procedure to be followed and the issues involved in the proceedings. Any party who appears representing himself or herself shall be advised by the industrial appeals judge of the burden of proof required to establish a right to the relief being sought.

(7) **How to make an appearance.**

(a) Appearance by employer representative. Within fourteen days of receipt of an order granting appeal, any representative of an employer or retrospective rating group must file a written notice of appearance that includes the name, address, and telephone number of the individual who will appear.

(b) Appearances by a worker or beneficiary representative shall be made either by:

(i) Filing a written notice of appearance with the board containing the name of the party to be represented, and the name and address of the representative; or by

(ii) Appearing at the time and place of a conference or hearing on the appeal, and notifying the industrial appeals judge of the party to be represented, and the name and address of the representative.

(8) **Notice to other parties.**

(a) The appearing party shall furnish copies of every written notice of appearance to all other parties or their representatives of record at the time the original notice is filed with the board.

(b) The board will serve all of its notices and orders on each representative and each party represented. Service upon the representative shall constitute service upon the party. Where more than one individual associated with a firm, or organization, including the office of the attorney general, has made an appearance, service under this subsection shall be satisfied by serving the individual who filed the notice of appeal, or who last filed a written notice of appearance or, if

no notice of appeal or written notice of appearance has been filed on behalf of the party, the individual who last appeared at any proceeding concerning the appeal.

(9) **Withdrawal or substitution of representatives.** An attorney or other representative withdrawing from a case shall immediately notify the board and all parties of record in writing. The notice of withdrawal shall comply with the rules applicable to notices of withdrawal filed with the superior court in civil cases. Withdrawal is subject to approval by the industrial appeals judge or the ((~~executive secretary~~)) chief legal officer. Any substitution of an attorney or representative shall be accomplished by written notification to the board and to all parties of record together with the written consent of the prior attorney or representative. If such consent cannot be obtained, a written statement of the reason therefor shall be supplied.

(10) **Conduct.** All persons appearing as counsel or representatives in proceedings before the board or before its industrial appeals judges shall conform to the standards of ethical conduct required of attorneys before the courts of the state of Washington.

(a) Industrial appeals judge. If any such person does not conform to such standard, the industrial appeals judge presiding over the appeal, at his or her discretion and depending on all the circumstances, may take any of the following actions:

(i) Admonish or reprimand such person.

(ii) Exclude such person from further participation or adjourn the proceeding.

(iii) Certify the facts to the appropriate superior court for contempt proceedings as provided in RCW 51.52.100.

(iv) Report the matter to the board.

(b) The board. In its discretion, either upon referral by an industrial appeals judge as stated above or on its own motion, after information comes to light that establishes to the board a question regarding a person's ethical conduct and fitness to practice before the board, and after notice and hearing, the board may take appropriate disciplinary action including, but not limited to:

(i) A letter of reprimand.

(ii) Refusal to permit such person to appear in a representative capacity in any proceeding before the board or its industrial appeals judges.

(iii) Certification of the record to the superior court for contempt proceedings as provided in RCW 51.52.100. If the circumstances require, the board may take action as described above prior to notice and hearing if the conduct or fitness of the person appearing before the board requires immediate action in order to preserve the orderly disposition of the appeal(s).

(c) Proceedings. If any person in proceedings before the board disobeys or resists any lawful order or process, or misbehaves during a hearing or so near the place thereof as to obstruct the same, or neglects to produce, after having been ordered so to do, any pertinent book, paper or document, or refuses to appear after having been subpoenaed, or upon appearing refuses to take oath as a witness, or after having the oath refuses to be examined according to law, the industrial appeals judge may, at his or her discretion and depending on all the circumstances:

(i) Admonish or reprimand such person.

(ii) Exclude such person from further participation or adjourn the proceeding.

(iii) Certify the facts to the appropriate superior court for contempt proceedings as provided in RCW 51.52.100.

(iv) Report the matter to the board for action consistent with (b) of this subsection.

AMENDATORY SECTION (Amending WSR 06-12-003, filed 5/25/06, effective 6/25/06)

WAC 263-12-045 Industrial appeals judges. (1) **Definition.** Whenever used in these rules, the term "industrial appeals judge" shall include any member of the board, the ((~~executive secretary, as well as~~)) chief legal officer, and any duly authorized industrial appeals judge assigned to conduct a conference or hearing.

(2) **Duties and powers.** It shall be the duty of the industrial appeals judge to conduct conferences or hearings in cases assigned to him or her in an impartial and orderly manner. The industrial appeals judge shall have the authority, subject to the other provisions of these rules:

(a) To administer oaths and affirmations;

(b) To issue subpoenas on request of any party or on his or her motion. Subpoenas may be issued to compel:

(i) The attendance and testimony of witnesses at hearing and/or deposition, or

(ii) The production of books, papers, documents, and other evidence for discovery requests or proceedings before the board;

(c) To rule on all objections and motions including those pertaining to matters of discovery or procedure;

(d) To rule on all offers of proof and receive relevant evidence;

(e) To interrogate witnesses called by the parties in an impartial manner to develop any facts deemed necessary to fairly and adequately decide the appeal;

(f) To secure and present in an impartial manner such evidence, in addition to that presented by the parties, as he or she deems necessary to fairly and equitably decide the appeal, including the obtaining of physical, mental, or vocational examinations or evaluations of workers;

(g) To take appropriate disciplinary action with respect to representatives of parties appearing before the board;

(h) To issue orders joining other parties, on motion of any party, or on his or her own motion when it appears that such other parties may have an interest in or may be affected by the proceedings;

(i) To consolidate appeals for hearing when such consolidation will expedite disposition of the appeals and avoid duplication of testimony and when the rights of the parties will not be prejudiced thereby;

(j) To schedule the presentation of evidence and the filing of pleadings, including the filing of perpetuation depositions;

(k) To close the record on the completion of the taking of all evidence and the filing of pleadings and perpetuation depositions. In the event that the parties do not confirm witnesses or present their evidence within the timelines prescribed by the judge, the judge may consider appropriate

sanctions, including closing the record and issuing a proposed decision and order;

(l) To take any other action necessary and authorized by these rules and the law.

(3) **Interlocutory review.** A party may request interlocutory review pursuant to WAC 263-12-115(6) of any exercise of authority by the industrial appeals judge under this rule.

(4) **Substitution of industrial appeals judge.** At any time the board or a chief industrial appeals judge or designee may substitute one industrial appeals judge for another in any given appeal.

(5) **Pro tem industrial appeals judge.** If the board or the chief industrial appeals judge determines that there may be a conflict of interest for an industrial appeals judge to hear a particular appeal or when it is necessary to ensure an appearance of fairness or respond to workload variations, the board may appoint a pro tem industrial appeals judge to preside over the appeal and, if necessary, issue a proposed decision and order.

AMENDATORY SECTION (Amending WSR 14-24-105, filed 12/2/14, effective 1/2/15)

WAC 263-12-052 Contents of claim resolution ((~~structured~~)) settlement agreement. A claim resolution ((~~structured~~)) settlement agreement shall be submitted electronically with a signed copy of the agreement. If the worker is not represented by an attorney, the agreement shall ((~~contain~~)) address all of the following information. If the worker is represented by an attorney, the agreement does not need to ((~~include~~)) address the information requested in subsections (6) through (9) of this section:

(1) The names and mailing addresses of the parties to the agreement;

(2) The date of birth of the worker;

(3) The date the claim was received by the department or the self-insured employer, and the claim number;

(4) The date of the order allowing the claim and the date the order became final. If the date of the order is unknown, a statement that the claim has been filed longer than one hundred eighty days prior and allowance of the claim became final;

(5) The payment schedule and amounts to be paid through the claim resolution ((~~structured~~)) settlement agreement;

(6) The nature and extent of the injuries and disabilities of the worker and the conditions accepted and segregated in the claim;

(7) The life expectancy of the worker;

(8) Other benefits the worker is receiving or is entitled to receive and the effect that a claim resolution ((~~structured~~)) settlement agreement may have on those benefits;

(9) The marital or domestic partnership status of the worker;

(10) The number of dependents, if any, the worker has;

(11) ((~~A statement that:~~)) (a) The worker knows that he/she has the right to:

(i) Continue to receive all the benefits for which they are eligible under this title;

(ii) Participate in vocational training if eligible; or

(iii) Resolve their claim with a ((~~structured~~)) settlement;

(b) All parties have signed the agreement. If a state fund employer has not signed the agreement, a statement that:

(i) The cost of the settlement will no longer be included in the calculation of the employer's experience factor used to determine premiums; or

(ii) The employer cannot be located; or

(iii) The employer is no longer in business; or

(iv) The employer failed to respond or declined to participate after timely notice of the claim resolution settlement process provided by the department;

(c) The parties are seeking approval by the board of the agreement;

(d) The agreement binds parties with regard to all aspects of the claim except medical benefits;

(e) The periodic payment schedule is equal to at least twenty-five percent but not more than one hundred fifty percent of the average monthly wage in the state pursuant to RCW 51.08.018, except for the initial payment which may be up to six times the average monthly wage in the state pursuant to RCW 51.08.018;

(f) The agreement does not set aside or reverse an allowance order;

(g) The agreement does not subject any employer who is not a signatory to the agreement to any responsibility or burden under any claim;

(h) The agreement does not subject any department funds covered under the title to any responsibility or burden without prior approval from the director or his/her designee;

(i) The unrepresented worker or beneficiary of a self-insured employer was informed that he/she may request that the office of the ombudsman for self-insured injured workers provide assistance or be present during the negotiations;

(j) The claim will remain open for treatment or that the claim will be closed;

(k) The worker will either be required to or not be required to demonstrate aggravation ((~~of accepted conditions~~)) as contemplated by RCW 51.32.160 if the worker applies to reopen the claim;

(l) The parties understand and agree to the terms of the agreement;

(m) The parties have entered into the agreement knowingly and willingly, without harassment or coercion;

(n) The parties have represented the facts and the law to each other to the best of their knowledge;

(o) The parties believe that the agreement is reasonable under the circumstances;

(p) The parties know that they may revoke consent to the agreement by providing written notice to the other parties and the board within thirty days after the agreement is approved by the board;

(q) The designation of the party that will apply for approval with the board;

(r) Restrictions on the assignment, if any, of rights and benefits under the claim resolution ((~~structured~~)) settlement agreement.

(12) If the agreement impacts any claim with a currently active appeal, the proceedings in the appeal will be stayed without further order. Unless the agreement specifies other-

wise and the agreement is approved, the appeal will be dismissed after the expiration of the revocation period specified in RCW 51.04.063(6).

NEW SECTION

WAC 263-12-05301 Amendments of claim resolution settlement agreement. Amendments to claim resolution settlement agreements are permitted without the requirement to refile the agreement when requested prior to approval or rejection by the board of the claim resolution settlement agreement and signed consent to the amendment is obtained from all original signatories. In such cases the board's approval or rejection will specify the amendments made to the original agreement.

AMENDATORY SECTION (Amending WSR 91-13-038, filed 6/14/91, effective 7/15/91)

WAC 263-12-091 Affidavits of prejudice. Affidavits of prejudice against an industrial appeals judge ((~~assigned to conduct hearings~~)) in an appeal ((~~are subject to the provisions of RCW 4.12.050~~)) will disqualify a judge from hearing or deciding a matter, except ((~~that~~)) only one affidavit may be filed by a party in an appeal and such affidavit must be filed:

(1) Within thirty days of receipt of the notice of assignment of the appeal to the industrial appeals judge or prior to the assigned industrial appeals judge holding any proceeding in the appeal, whichever occurs sooner; or

(2) Within five business days of notification that the appeal has been assigned to a new industrial appeals judge for the purpose of writing a proposed decision and order.

AMENDATORY SECTION (Amending WSR 06-12-003, filed 5/25/06, effective 6/25/06)

WAC 263-12-097 Interpreters. (1) When an impaired person as defined in chapter 2.42 RCW or a non-English-speaking person as defined in chapter 2.43 RCW is a party or witness in a hearing before the board of industrial insurance appeals, the industrial appeals judge may appoint an interpreter to assist the party or witness throughout the proceeding. Appointment, qualifications, waiver, compensation, visual recording, and ethical standards of interpreters in adjudicative proceedings are governed by the provisions of chapters 2.42 and 2.43 RCW and General Rule provisions GR 11, GR 11.1, and GR 11.2.

(2) The provisions of General Rule 11.3 regarding telephonic interpretation and General Rule 11.4 regarding team interpretation shall not apply to the board's use of interpreters.

(3) The industrial appeals judge shall make a preliminary determination that an interpreter is able to accurately interpret all communication to and from the impaired or non-English-speaking person and that the interpreter is impartial. The interpreter's ability to accurately interpret all communications shall be based upon either (a) certification by the office of the administrator of the courts, or (b) the interpreter's education, certifications, experience, and the interpreter's understanding of the basic vocabulary and procedure involved in the proceeding. The parties or their representatives may question the interpreter as to his or her qualifications or impartiality.

(4) The board of industrial insurance appeals will pay interpreter fees and expenses when the industrial appeals judge has determined the need for interpretive services as set forth in subsection (1). When a party or person for which interpretive services were requested fails to appear at the proceeding, the requesting party or the party's representative may be required to bear the expense of providing the interpreter.

AMENDATORY SECTION (Amending WSR 17-24-121, filed 12/6/17, effective 1/6/18)

WAC 263-12-117 Perpetuation depositions. (1) **Evidence by deposition.** The industrial appeals judge may permit or require the perpetuation of testimony by deposition, subject to the applicable provisions of WAC 263-12-115. Such ruling may only be given after the industrial appeals judge gives due consideration to:

(a) The complexity of the issues raised by the appeal;

(b) The desirability of having the witness's testimony presented at a hearing;

(c) The costs incurred by the parties in complying with the ruling; and

(d) The fairness to the parties in complying with the ruling.

(2) **Telephone depositions:** When testimony is taken by perpetuation deposition, it may be taken by telephone if all parties agree. For good cause the industrial appeals judge may permit the parties to take the testimony of a witness by telephone deposition over the objection of a party after weighing the following nonexclusive factors:

- The need of a party to observe a witness's demeanor.
- Difficulty in handling documents and exhibits.
- The number of parties participating in the deposition.
- Whether any of the testimony will need to be translated.
- Ability of the witness to travel.
- Availability of quality telecommunications equipment and service.

If a perpetuation deposition is taken by telephone, the court reporter transcribing the deposition is authorized to swear in the deponent, regardless of the deponent's location within or outside the state of Washington.

(3) The industrial appeals judge may require that depositions be taken and published within prescribed time limits. The time limits may be extended by the industrial appeals judge for good cause. Each party shall bear its own costs except when the industrial appeals judge allocates costs to parties or their representatives. If a party takes a deposition under this section, but elects not to file the deposition as evidence in the appeal, the party shall provide written notice to the assigned industrial appeals judge and all other parties prior to the deposition filing deadline.

(4) The party filing a deposition must submit the stenographically reported and transcribed deposition, certification, and exhibits in ((~~both a written format and~~)) an electronic format in accordance with procedures established by the board. The following requirements apply to the submission of depositions:

(a) Video depositions will not be considered as part of the record on appeal;

(b) The electronic deposition must be submitted in searchable pdf format;

(c) Exhibits to the deposition must be filed electronically as a single attachment separate from the deposition transcript and certification;

(d) ((~~A legible paper copy of all exhibits must accompany the paper deposition transcript;~~

~~(e)~~)) Any media exhibit (audio or video) must meet the requirements set forth in WAC 263-12-116; and

(((~~(f)~~))) (e) If the deposition is not transcribed in a reproducible format or properly submitted it may be excluded from the record.

(5) **Procedure at deposition.** Unless the parties stipulate or the industrial appeals judge determines otherwise all depositions permitted to be taken for the perpetuation of testimony shall be taken subject to the following conditions:

(a) That all motions and objections, whether to form or otherwise, shall be raised at the time of the deposition and if not raised at such time shall be deemed waived.

(b) That all exhibits shall be marked and identified at the time of the deposition and, if offered into evidence, appended to the deposition.

(c) That the deposition be published without necessity of further conference or hearing at the time it is received by the industrial appeals judge.

(d) That all motions, including offers to admit exhibits and objections raised at the time of the deposition, shall be ruled upon by the industrial appeals judge in the proposed decision and order.

(e) That the deposition may be appended to the record as part of the transcript, and not as an exhibit, without the necessity of being retyped into the record.

AMENDATORY SECTION (Amending WSR 16-24-054, filed 12/2/16, effective 1/2/17)

WAC 263-12-118 Motions. (1) **Definition.** A party's written or oral request for the board to take action on a pending appeal is a "motion." Motions must be in writing unless made during a hearing before an industrial appeals judge. The board recognizes that there are two basic categories of motions:

(a) **Nondispositive motions.** Nondispositive motions include procedural motions, such as motions for a continuance, an extension of time, or to reopen the record; and discovery motions, such as motions *in limine* or motions to compel or request sanctions.

(b) **Dispositive motions.** Dispositive motions ask for a decision on one or more of the issues in an appeal or to dismiss the appeal. Examples of dispositive motions are motions to dismiss or motions for summary judgment. See WAC 263-12-11801.

(2) **Motions made to the ((~~executive secretary~~)) chief legal officer.** The procedural rules in subsections (3) through (6) of this section do not apply to motions made to the ((~~executive secretary~~)) chief legal officer for consideration by the three-member board:

(a) Motions for stay of the order on appeal under RCW 51.52.050 (2)(b). (See WAC 263-12-11802.)

(b) Motions to reconsider or vacate final board orders. (See WAC 263-12-156.)

(c) Motions to set reasonable attorneys' fees under RCW 51.52.120. (See WAC 263-12-165.)

(d) Requests for a stay of abatement pending appeal under RCW 49.17.140 (4)(a) in appeals filed under the Washington Industrial Safety and Health Act. (See WAC 263-12-059.)

(3) **Written motions.** A written motion must identify the action requested on the first page in bold print. See WAC 263-12-01501 for other information about communication and filing.

(4) **Oral motions.** Any party may bring an oral motion during a hearing, unless prohibited from doing so at the industrial appeals judge's discretion. The industrial appeals judge may provide an opportunity for other parties to respond to any oral motion. The industrial appeals judge may require that an oral motion also be submitted in writing and may provide an opportunity for written response.

(5) **Responses to nondispositive motions.** Any party who opposes a written nondispositive motion may file a written response within five business days after the motion is served, or may make an oral or written response at such other time as the industrial appeals judge may set.

(6) **Argument.**

(a) **Nondispositive motions.** All nondispositive motions will be ruled on without oral argument, unless it is requested by the parties and approved by the industrial appeals judge, or at the discretion of the industrial appeals judge. Any party may request oral argument by placing "ORAL ARGUMENT REQUESTED" prominently on the first page of the motion or responsive pleading. The time and date for oral argument shall be scheduled in advance by contacting the judicial assistant for the assigned industrial appeals judge. Written notice shall be mailed not less than seven calendar days prior to the date set for oral argument, unless waived by the parties.

(b) **Dispositive motions.** See WAC 263-12-11801.

AMENDATORY SECTION (Amending WSR 91-13-038, filed 6/14/91, effective 7/15/91)

WAC 263-12-170 Appeals to superior court—Certification of record. Upon receipt of a copy of notice of appeal to superior court from a board order, served upon the board by the appealing party pursuant to RCW 51.52.110, 7.68.110, 51.48.131, 34.05.542 or 49.17.150, the ((~~executive secretary~~)) chief legal officer or his or her designee shall certify the record made before the board to the court pursuant to the provisions of RCW 51.52.110, 7.68.110, 51.48.131, 34.05.-566 or 49.17.150. Copies of such record (except nonreproducible exhibits) shall be furnished to all parties to the proceedings before the board.

AMENDATORY SECTION (Amending WSR 18-24-123, filed 12/5/18, effective 1/5/19)

WAC 263-12-195 Significant decisions. (1) The board's publication "*Significant Decisions*," prepared pursuant to RCW 51.52.160, contains the decisions or orders of the

board which it considers to have an analysis or decision of substantial importance to the board in carrying out its duties. Together with the indices of decision maintained pursuant to WAC 263-12-016(4), "*Significant Decisions*" shall serve as the index required by RCW 42.56.070 (5)(a) and (b).

(2) The board selects the decisions or orders to be included in "*Significant Decisions*" based on recommendations from staff and the public. Generally, a decision or order is considered "significant" only if it provides a legal analysis or interpretation not found in existing case law, or applies settled law to unusual facts. Decisions or orders may be included which demonstrate the application of a settled legal principle to varying fact situations or which reflect the further development of, or continued adherence to, a legal principle previously recognized by the board. Nominations of decisions or orders for inclusion in "*Significant Decisions*" should be submitted in writing to the ((~~executive secretary~~)) chief legal officer.

(3) "*Significant Decisions*" consists of decisions and orders identified as significant and headnotes summarizing the proposition or propositions for which the board considers the decisions or orders "significant." Indices are also provided to identify each decision or order by name and by subject.

(4) "*Significant Decisions*" and indices may be accessed at the board's web site, www.biia.wa.gov.

WSR 21-10-094
PROPOSED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES

[Filed May 4, 2021, 3:08 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 20-08-093.

Title of Rule and Other Identifying Information: The department is proposing to amend chapter 388-71 WAC, Home and community services and programs; chapter 388-106 WAC, Long-term care services; and chapter 388-113 WAC, Disqualifying crimes and negative actions. The department is also proposing to create a new chapter 388-115 WAC, Consumer directed employer (CDE).

Hearing Location(s): On July 6, 2021, 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 7, 2021.

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 7, 2021.

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 May 22, 2021.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The department is proposing to amend, repeal, and create new sections in chapters 388-71, 388-106, and 388-113 WAC, and create a new chapter 388-115 WAC, Consumer directed employer, as a reference for the individual providers employed by the CDE.

The purpose for making changes is to clarify and consolidate rules related to background checks, disqualifying convictions, and negative actions; and character, competence, and suitability determinations for home and community services, residential care services, and the developmental disabilities administration. These changes will provide better clarity and understanding for the public and contracted entities, reduce the amount of WAC language across programs, and help preserve the health and safety of our clients. Other provisions related to long-term care worker qualifications and a client's choice of provider will also be clarified and consolidated.

Reasons Supporting Proposal: The department is making these changes based on the implementation of the CDE and the change from individual providers contracted with the department to individual providers employed by CDE as a result of the passage of ESSB 6199 (chapter 278, Laws of 2018) in 2018.

Statutory Authority for Adoption: RCW 74.08.090, 74.09.520, 43.43.832, 74.39A.270, 74.39A.056, 74.39A.074, 43.20A.710, 74.39A.525, 43.43.842, 74.39A.326, 74.39A.515, 74.39A.505, 18.88B.021, and 43.43.837.

Statute Being Implemented: RCW 74.08.090, 74.09.520, 43.43.832, 74.39A.270, 74.39A.056, 74.39A.074, 43.20A.710, 74.39A.525, 43.43.842, 74.39A.326, 74.39A.515, 74.39A.505, 18.88B.021, and 43.43.837.

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

Name of Proponent: DSHS, governmental.

Name of Agency Personnel Responsible for Drafting and Implementation: Carson Crepeaux, P.O. Box 45600, Olympia, WA 98504-5600, 360-725-3714; Enforcement: Karen Fitzharris, P.O. Box 45600, Olympia, WA 98504-5600, 360-725-2536.

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 Angel Sulivan, P.O. Box 45600, Olympia, WA 98504-5600, phone 360-725-2495, fax 360-407-7582, TTY 360-493-2637, email Angel.Sulivan@dshs.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 19.85.025(4) because the proposed amendments impose no new or disproportionate costs on small businesses so a small business economic impact statement is not required.

April 29, 2021
Katherine I. Vasquez
Rules Coordinator

Reviser's note: The material contained in this filing exceeded the page-count limitations of WAC 1-21-040 for appearance in this issue of the Register. It will appear in the 21-12 issue of the Register.

WSR 21-10-095
PROPOSED RULES
HEALTH CARE AUTHORITY
[Filed May 5, 2021, 8:19 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 21-05-010.

Title of Rule and Other Identifying Information: WAC 182-535 Dental-related services, 182-535-1050 Definitions, 182-535-1080 Covered—Diagnostic, 182-535-1082 Covered—Preventative services, 182-535-1084 Dental-related services—Covered—Restorative services, 182-535-1090 Dental-related services—Covered—Prosthodontics (removable), 182-535-1094 Dental-related services—Covered—Oral and maxillofacial surgery services, 182-535-1098 Covered—Adjunctive general services, 182-535-1099 Dental-related services for clients of the developmental disabilities administration of the department of social and health services, 182-535-1220 Obtaining prior authorization for dental-related services, and 182-535-1245 Access to baby and child dentistry (ABCD) program.

Hearing Location(s): On June 8, 2021, at 10:00 a.m. In response to the coronavirus disease 2019 (COVID-19) public health emergency, the agency will not provide a physical location for this hearing. This promotes 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 attend the virtual public hearing, you must register at the following link https://attendee.gotowebinar.com/register/8620587191761803532, Webinar ID 384-227-715. After registering, you will receive a confirmation email containing the information about joining the webinar.

Date of Intended Adoption: Not sooner than June 9, 2021.

Submit Written Comments to: Health Care Authority (HCA) Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, by June 8, 2021.

Assistance for Persons with Disabilities: Contact Amber Lougheed, phone 360-725-1349, fax 360-586-9727, telecommunication[s] relay service 711, email amber.lougheed@hca.wa.gov, by May 21, 2021.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: WAC 182-535-1050, added definitions for alveoloplasty, mobile anesthesiologist, and resin-based composite restorations. Amended definition for comprehensive oral evaluation to "may include periodontal charting" to align with current dental terminology (CDT) definition. Amended definition of prophylaxis to remove "tooth" and replace with "tooth structures and implants and is intended to control local irritation factors" to align with CDT definition. Removed definition of flowable composite as it is now described in the newly added definition of resin-based composite restorations.

WAC 182-535-1080 (2)(c), removed "at least" and replaced with "typically" to make the amount of films necessary for full mouth set of x-rays less restrictive.

WAC 182-535-1080 (3)(b), removed subsection. The agency no longer accepts study models.

WAC 182-535-1082 (1)(a), removed "primary or permanent dentition" and replace with "tooth structures and implants" to align with CDT definition.

WAC 182-535-1082 (1)(b)(i)(B) and (c)(i)(B), added "Of any age" to residing in an alternate living facility or nursing facility to clarify there is no age limits. Restructured subsection to remove redundant language and provide clearer reading.

WAC 182-535-1082(2), restructured subsection to remove redundant language and provide clearer reading. No policy change.

WAC 182-535-1082(5), removed subsection. Tobacco cessation is not reimbursable for dental providers.

WAC 182-535-1082 (6)(b), removed subsection. Glass ionomer cements have improved and are considered a suitable material to be used as sealants.

WAC 182-535-1084 (1), (2)(b), added glass ionomer to listed restorations.

WAC 182-535-1084 (2)(e), removed subsection. Dental providers use letters to identify tooth surfaces and no longer use the term "incisal angle."

WAC 182-535-1084 (2)(f), amended subsection to only say "Does not cover preventative restorations." This amendment reflects the improved properties of current composite materials and no longer require the restrictions.

WAC 182-535-1084 (2)(g), amended subsection to allow for coverage of replacement restorations that are cracked or broken, between six and twenty-four months of original placement, with approved prior authorization.

WAC 182-535-1084 (2)(h), amended subsection to clarify that replacement of a cracked or broken restoration within a six-month period by the same provider is considered part of the global payment of the initial restoration and is not paid separately. HCA expects restorations to last a minimum of two years. Providers must guarantee their work, at their cost, for at least six months to ensure a quality restoration. Removed last sentence in previous subsection (2)(h) "The agency pays for the replacement restoration as one multisurface restoration." Restorations are commonly paid for as surfaces billed.

WAC 182-535-1084(3), removed subsection titled "Additional limitations for restorations on primary teeth." Surfaces treated are surfaces that can be billed. This removes the limits.

WAC 182-535-1084 (5)(b)(i) and (ii), removed subsections and combine into subsection (5)(c).

WAC 182-535-1084 (5)(c), revised to include "… for clients ages zero through twelve and with prior authorization for clients age thirteen through twenty" for prefabricated stainless steel crowns. Revised subsections (i) - (iv) to include decay information.

WAC 182-535-1084 (5)(e), added new subsection "Prefabricated stainless-steel crowns, for permanent posterior teeth, excluding one, sixteen, seventeen, and thirty-two for clients age twenty-one and older in lieu of a restoration

requiring three or more surfaces." Coverage is no longer restricted to clients age twenty-one and younger.

WAC 182-535-1090 (1)(b)(iii), added "restorative" and "in the arch(es) being request" for clarification to specify arch designation for prosthodontics.

WAC 182-535-1090 (2)(a)(iii), added "and the replacement is medically necessary. Prior authorization is required for replacement dentures with evidence of medical necessity" to clarify the intent for replacement dentures is that they are medically necessary and not just replaced because a specific time frame has gone by. Remove "the replacement does not require prior authorization."

WAC 182-535-1090 (3)(a)(i), removed "free of periodontal disease" and replaced with "periodontally stable" and "periodontal" prognosis. The agency is aware that the expectation is not to cure periodontal disease but rather the periodontal disease is managed in order to provide a stable foundation and the required three-year prognosis for a resin partial denture.

WAC 182-535-1090 (3)(d), added that the replacement must be medically necessary. Prior authorization is required for replacement dentures with evidence of medical necessity. The intent for replacement dentures is that they are medically necessary and not just replaced because a specific time frame has gone by.

WAC 182-535-1094(2), revised alveoplasty policy. Removed "prior authorization is not required" language.

WAC 182-535-1098 (1)(c)(ii), corrected cross reference - housekeeping.

WAC 182-535-1099 (1)(e), added cross reference for sealant coverage.

WAC 182-535-1099 (3)(b)(v), added "allowed once in a twelve-month period" to establish a limitation for full mouth scaling.

WAC 182-535-1220 (3)(b), removed "study models" as they are no longer used.

WAC 182-535-1220(4), amended doctor of dental medicine to "medicine in dentistry" for clarification.

WAC 182-535-1245 (1)(d), amended "nondental" to "medical" provider to clarify nondental providers are medical providers.

WAC 182-535-1245 (3)(a)(ii)(F), amended "and duration of" to "at" for clarification of reading.

WAC 182-535-1245 (3)(f)(i), added "glass ionomer" to clarify this is a covered service.

Reasons Supporting Proposal: See purpose.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Statute Being Implemented: RCW 41.05.021, 41.05.160.

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: Not applicable.

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Valerie Freudenstein, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-1344; Implementation and Enforcement: Pixie Needham, P.O. Box 45506, Olympia, WA 98504-5506, 360-725-9967.

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 rule does not impose any additional costs on businesses.

May 5, 2021
Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 19-20-047, filed 9/25/19, effective 10/26/19)

WAC 182-535-1050 Definitions. The following definitions and abbreviations and those found in chapter 182-500 WAC apply to this chapter. The medicaid agency also uses dental definitions found in the American Dental Association's Current Dental Terminology (CDT) and the American Medical Association's Physician's Current Procedural Terminology (CPT). Where there is any discrepancy between the CDT or CPT and this section, this section prevails. (CPT is a trademark of the American Medical Association.)

"Access to baby and child dentistry (ABCD)" is a program to increase access to dental services for medicaid eligible infants, toddlers, and preschoolers through age five. See WAC 182-535-1245 for specific information.

"Alternate living facility" is defined in WAC 182-513-1100.

"American Dental Association (ADA)" is a national organization for dental professionals and dental societies.

"Anterior" refers to teeth (maxillary and mandibular incisors and canines) and tissue in the front of the mouth. Permanent maxillary anterior teeth include teeth six, seven, eight, nine, ten, and eleven. Permanent mandibular anterior teeth include teeth twenty-two, twenty-three, twenty-four, twenty-five, twenty-six, and twenty-seven. Primary maxillary anterior teeth include teeth C, D, E, F, G, and H. Primary mandibular anterior teeth include teeth M, N, O, P, Q, and R.

"Asynchronous" means two or more events not happening at the same time.

"Alveoloplasty" means a distinct (separate procedure) from extractions. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery.

"Behavior management" means using one additional professional staff, who is employed by the dental provider or clinic and who is not delivering dental treatment to the client, to manage the client's behavior to facilitate dental treatment delivery.

"By-report" means a method of reimbursement in which the department determines the amount it will pay for a service when the rate for that service is not included in the agency's published fee schedules. Upon request the provider must submit a "report" that describes the nature, extent, time, effort and/or equipment necessary to deliver the service.

"Caries" means carious lesions or tooth decay through the enamel or decay on the root surface.

• **"Incipient caries"** means the beginning stages of caries or decay, or subsurface demineralization.

• **"Rampant caries"** means a sudden onset of widespread caries that affects most of the teeth and penetrates quickly to the dental pulp.

"Comprehensive oral evaluation" means a thorough evaluation and documentation of a client's dental and medical history to include extra-oral and intra-oral hard and soft tissues, dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions ((~~(including periodontal)~~)), (may include periodontal screening and/or charting), hard and soft tissue anomalies, and oral cancer screening.

"Conscious sedation" means a drug-induced depression of consciousness during which a client responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, spontaneous ventilation is adequate, and cardiovascular function is maintained.

"Core buildup" means the building up of clinical crowns, including pins.

"Coronal" means the portion of a tooth that is covered by enamel.

"Crown" means a restoration covering or replacing the whole clinical crown of a tooth.

"Current dental terminology (CDT)" means a systematic listing of descriptive terms and identifying codes for reporting dental services and procedures performed by dental practitioners. CDT is published by the Council on Dental Benefit Programs of the American Dental Association (ADA).

"Current procedural terminology (CPT)" means a systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians and other practitioners who provide physician-related services. CPT is copyrighted and published annually by the American Medical Association (AMA).

"Decay" means a term for caries or carious lesions and means decomposition of tooth structure.

"Deep sedation" means a drug-induced depression of consciousness during which a client cannot be easily aroused, ventilatory function may be impaired, but the client responds to repeated or painful stimulation.

"Dental general anesthesia" see **"general anesthesia."**

"Dentures" means an artificial replacement for natural teeth and adjacent tissues, and includes complete dentures, immediate dentures, overdentures, and partial dentures.

"Denturist" means a person licensed under chapter 18.30 RCW to make, construct, alter, reproduce, or repair a denture.

"Distant site (location of dental provider)" means the physical location of the dentist or authorized dental provider providing the dental service to a client through teledentistry.

"Edentulous" means lacking teeth.

"Endodontic" means the etiology, diagnosis, prevention and treatment of diseases and injuries of the pulp and associated periradicular conditions.

"EPSDT" means the agency's early and periodic screening, diagnostic, and treatment program for clients age twenty and younger as described in chapter 182-534 WAC.

"Extraction" see **"simple extraction"** and **"surgical extraction."**

((~~**"Flowable composite"** means a diluted low-viscosity-filled resin-based composite dental restorative material that is used in cervical restorations and small, low-stress bearing occlusal restorations.~~))

"Fluoride varnish, rinse, foam or gel" means a substance containing dental fluoride which is applied to teeth, not including silver diamine fluoride.

"General anesthesia" means a drug-induced loss of consciousness during which a client is not arousable even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Clients may require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

"Interim therapeutic restoration (ITR)" means the placement of an adhesive restorative material following caries debridement by hand or other method for the management of early childhood caries. It is not considered a definitive restoration.

"Limited oral evaluation" means an evaluation limited to a specific oral health condition or problem. Typically a client receiving this type of evaluation has a dental emergency, such as trauma or acute infection.

"Limited visual oral assessment" means an assessment by a dentist or dental hygienist provided in a setting other than a dental office or dental clinic to identify signs of disease and the potential need for referral for diagnosis.

"Medically necessary" see WAC 182-500-0070.

"Mobile anesthesiologist" means a provider qualified to deliver moderate and deep sedation in an office setting other than their own. The mobile anesthesiologist is a separate provider from the clinician delivering dental treatment.

"Oral evaluation" see **"comprehensive oral evaluation."**

"Oral hygiene instruction" means instruction for home oral hygiene care, such as tooth brushing techniques or flossing.

"Originating site (location of client)" means the physical location of the medicaid client as it relates to teledentistry.

"Partials" or **"partial dentures"** mean a removable prosthetic appliance that replaces missing teeth on either arch.

"Periodic oral evaluation" means an evaluation performed on a patient of record to determine any changes in the client's dental or medical status since a previous comprehensive or periodic evaluation.

"Periodontal maintenance" means a procedure performed for clients who have previously been treated for periodontal disease with surgical or nonsurgical treatment. It includes the removal of supragingival and subgingival microorganisms, calculus, and deposits with hand and mechanical instrumentation, an evaluation of periodontal conditions, and a complete periodontal charting as appropriate.

"Periodontal scaling and root planing" means a procedure to remove plaque, calculus, microorganisms, and rough cementum and dentin from tooth surfaces. This includes hand and mechanical instrumentation, an evaluation of periodontal conditions, and a complete periodontal charting as appropriate.

"Posterior" means the teeth (maxillary and mandibular premolars and molars) and tissue towards the back of the mouth. Permanent maxillary posterior teeth include teeth one, two, three, four, five, twelve, thirteen, fourteen, fifteen, and sixteen. Permanent mandibular posterior teeth include teeth seventeen, eighteen, nineteen, twenty, twenty-one, twenty-eight, twenty-nine, thirty, thirty-one, and thirty-two. Primary maxillary posterior teeth include teeth A, B, I, and J. Primary mandibular posterior teeth include teeth K, L, S, and T.

"Prophylaxis" means the dental procedure of scaling and polishing which includes removal of calculus, plaque, and stains from ((~~teeth~~)) tooth structures and implants and is intended to control local irritation factors.

"Proximal" means the surface of the tooth near or next to the adjacent tooth.

"Radiograph (X-ray)" means an image or picture produced on a radiation sensitive film emulsion or digital sensor by exposure to ionizing radiation.

"Reline" means to resurface the tissue side of a denture with new base material or soft tissue conditioner in order to achieve a more accurate fit.

"Resin-based composite restorations" means resin-based composite refers to a broad category of materials including, but not limited to, composites. The category may include bonded composite, light-cured composite, etc. Tooth preparation, acid-etching, adhesives (including resin-bonding agents), liners and bases, and curing are included as part of the restoration. Glass ionomers, when used as definitive restorations, should be reported with resin-based composite codes.

"Root canal" means the chamber within the root of the tooth that contains the pulp.

"Root canal therapy" means the treatment of the pulp and associated periradicular conditions.

"Root planing" means a procedure to remove plaque, calculus, microorganisms, and rough cementum and dentin from tooth surfaces. This includes hand and mechanical instrumentation.

"Scaling" means a procedure to remove plaque, calculus, and stain deposits from tooth surfaces.

"Sealant" means a dental material applied to teeth to prevent dental caries.

"Simple extraction" means the extraction of an erupted or exposed tooth to include the removal of tooth structure, minor smoothing of socket bone, and closure, as necessary.

"Standard of care" means what reasonable and prudent practitioners would do in the same or similar circumstances.

"Surgical extraction" means the extraction of an erupted or impacted tooth requiring removal of bone and/or sectioning of the tooth, and including elevation of mucoperiosteal flap if indicated. This includes related cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone, and closure.

"Synchronous" means existing or occurring at the same time.

"Teledentistry" means the variety of technologies and tactics used to deliver HIPAA-compliant, interactive, real-time audio and video telecommunications (including web-based applications) or store-and-forward technology to deliver covered services within the dental care provider's scope of practice to a client at a site other than the site where the provider is located.

"Temporomandibular joint dysfunction (TMJ/TMD)" means an abnormal functioning of the temporomandibular joint or other areas secondary to the dysfunction.

"Therapeutic pulpotomy" means the surgical removal of a portion of the pulp (inner soft tissue of a tooth), to retain the healthy remaining pulp.

"Usual and customary" means the fee that the provider usually charges nonmedicaid customers for the same service or item. This is the maximum amount that the provider may bill the agency.

AMENDATORY SECTION (Amending WSR 19-09-058, filed 4/15/19, effective 7/1/19)

WAC 182-535-1080 Covered—Diagnostic. Clients described in WAC 182-535-1060 are eligible to receive the dental-related diagnostic services listed in this section, subject to coverage limitations, restrictions, and client age requirements identified for a specific service.

(1) **Clinical oral evaluations.** The medicaid agency covers the following oral health evaluations and assessments, per client, per provider or clinic:

(a) Periodic oral evaluations as defined in WAC 182-535-1050, once every six months. Six months must elapse between the comprehensive oral evaluation and the first periodic oral evaluation.

(b) Limited oral evaluations as defined in WAC 182-535-1050, only when the provider performing the limited oral evaluation is not providing routine scheduled dental services for the client on the same day. The limited oral evaluation:

(i) Must be to evaluate the client for a:

(A) Specific dental problem or oral health complaint;

(B) Dental emergency; or

(C) Referral for other treatment.

(ii) When performed by a denturist, is limited to the initial examination appointment. The agency does not cover any additional limited examination by a denturist for the same client until three months after a removable prosthesis has been delivered.

(c) Comprehensive oral evaluations as defined in WAC 182-535-1050, once per client, per provider or clinic, as an initial examination. The agency covers an additional comprehensive oral evaluation if the client has not been treated by the same provider or clinic within the past five years.

(d) Limited visual oral assessments as defined in WAC 182-535-1050, two times per client, per provider in a twelve-month period only when the assessment is:

(i) Not performed in conjunction with other clinical oral evaluation services; and

(ii) Performed by a licensed dentist or dental hygienist to determine the need for sealants or fluoride treatment or when

triage services are provided in settings other than dental offices or clinics.

(2) **Radiographs (X-rays).** The agency:

(a) Covers radiographs per client, per provider or clinic, that are of diagnostic quality, dated, and labeled with the client's name. The agency requires:

(i) Original radiographs to be retained by the provider as part of the client's dental record; and

(ii) Duplicate radiographs to be submitted:

(A) With requests for prior authorization; or

(B) When the agency requests copies of dental records.

(b) Uses the prevailing standard of care to determine the need for dental radiographs.

(c) Covers an intraoral complete series once in a three-year period for clients age fourteen and older only if the agency has not paid for a panoramic radiograph for the same client in the same three-year period. The intraoral complete series typically includes ((~~at least~~)) fourteen to twenty-two periapical and posterior bitewings. The agency limits reimbursement for all radiographs to a total payment of no more than payment for a complete series.

(d) Covers medically necessary periapical radiographs for diagnosis in conjunction with definitive treatment, such as root canal therapy. Documentation supporting medical necessity must be included in the client's record.

(e) Covers an occlusal intraoral radiograph, per arch, once in a two-year period, for clients age twenty and younger.

(f) Covers a maximum of four bitewing radiographs once every twelve months.

(g) Covers panoramic radiographs in conjunction with four bitewings, once in a three-year period, only if the agency has not paid for an intraoral complete series for the same client in the same three-year period.

(h) Covers one preoperative and postoperative panoramic radiograph per surgery without prior authorization. The agency considers additional radiographs on a case-by-case basis with prior authorization. For orthodontic services, see chapter 182-535A WAC.

(i) Covers one preoperative and postoperative cephalometric film per surgery without prior authorization. The agency considers additional radiographs on a case-by-case basis with prior authorization. For orthodontic services, see chapter 182-535A WAC.

(j) Covers radiographs not listed as covered in this subsection, only on a case-by-case basis and when prior authorized.

(k) Covers oral and facial photographic images, only on a case-by-case basis and when requested by the agency.

(3) **Tests and examinations.** The agency covers the following for clients who are age twenty and younger:

((~~(a)~~)) One pulp vitality test per visit (not per tooth):

((~~(i)~~)) (a) For diagnosis only during limited oral evaluations; and

((~~(ii)~~)) (b) When radiographs or documented symptoms justify the medical necessity for the pulp vitality test.

((~~(b) Diagnostic casts other than those included in an orthodontic case study, on a case-by-case basis, and when requested by the agency.~~))

AMENDATORY SECTION (Amending WSR 19-09-058, filed 4/15/19, effective 7/1/19)

WAC 182-535-1082 Covered—Preventive services. Clients described in WAC 182-535-1060 are eligible for the dental-related preventive services listed in this section, subject to coverage limitations and client-age requirements identified for a specific service.

(1) **Prophylaxis.** The medicaid agency covers prophylaxis as follows. Prophylaxis:

(a) Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains when performed on ((~~primary or permanent dentition~~)) tooth structures and implants.

(b) Is limited to once every:

(i) Six months for clients ((~~age eighteen and younger~~)):

(A) Age eighteen and younger; or

(B) Of any age residing in an alternate living facility or nursing facility;

(ii) Twelve months for clients age nineteen and older((~~;~~ ~~or~~

~~(iii) Six months for a client residing in an alternate living facility or nursing facility~~)).

(c) Is reimbursed according to (b) of this subsection when the service is performed:

(i) At least six months after periodontal scaling and root planing, or periodontal maintenance services, for clients ((~~from~~)):

(A) Age thirteen through eighteen; or

(B) Of any age residing in an alternate living facility or nursing facility; or

(ii) At least twelve months after periodontal scaling and root planing, periodontal maintenance services, for clients age nineteen and older((~~; or~~

~~(iii) At least six months after periodontal scaling and root planing, or periodontal maintenance services for clients who reside in an alternate living facility or nursing facility~~)).

(d) Is not reimbursed separately when performed on the same date of service as periodontal scaling and root planing, periodontal maintenance, gingivectomy, gingivoplasty, or scaling in the presence of generalized moderate or severe gingival inflammation.

(e) Is covered for clients of the developmental disabilities administration of the department of social and health services (DSHS) according to (a), (c), and (d) of this subsection and WAC 182-535-1099.

(2) **Topical fluoride treatment.** The agency covers the following per client, per provider or clinic:

(a) Fluoride rinse, foam or gel, fluoride varnish, including disposable trays, ((~~for clients age six and younger,~~)) three times within a twelve-month period with a minimum of one hundred ten days between applications for clients:

(i) Age six and younger;

(ii) During orthodontic treatment.

(b) Fluoride rinse, foam or gel, fluoride varnish, including disposable trays, ((~~for clients from age seven through eighteen,~~)) two times within a twelve-month period with a minimum of one hundred seventy days between applications for clients:

(i) From age seven through eighteen; or

(ii) Of any age residing in alternate living facilities or nursing facilities.

(c) ((~~Fluoride rinse, foam or gel, fluoride varnish, including disposable trays, every three times within a twelve-month period during orthodontic treatment with a minimum of one hundred ten days between applications.~~

~~(d)~~)) Fluoride rinse, foam or gel, fluoride varnish, including disposable trays, for clients age nineteen and older, once within a twelve-month period.

(((~~(e) Fluoride rinse, foam or gel, fluoride varnish, including disposable trays, for clients who reside in alternate living facilities or nursing facilities, every two times within a twelve-month period with a minimum of one hundred seventy days between applications.~~

~~(f)~~)) (d) Additional topical fluoride applications only on a case-by-case basis and when prior authorized.

(((~~(g)~~)) (e) Topical fluoride treatment for clients of the developmental disabilities administration of DSHS according to WAC 182-535-1099.

(3) **Silver diamine fluoride.**

(a) The agency covers silver diamine fluoride as follows:

(i) When used for stopping the progression of caries or as a topical preventive agent;

(ii) Allowed two times per client per tooth in a twelve-month period; and

(iii) Cannot be billed with interim therapeutic restoration on the same tooth when arresting caries or as a preventive agent.

(b) The dental provider or office must have a signed informed consent form on file for each client receiving a silver diamine fluoride application. The form must include the following:

(i) Benefits and risks of silver diamine fluoride application;

(ii) Alternatives to silver diamine fluoride application; and

(iii) A color photograph example that demonstrates the post-procedure blackening of a tooth with silver diamine fluoride application.

(4) **Oral hygiene instruction.** Includes instruction for home care such as tooth brushing technique, flossing, and use of oral hygiene aids. Oral hygiene instruction is included as part of the global fee for prophylaxis for clients age nine and older. The agency covers individualized oral hygiene instruction for clients age eight and younger when all of the following criteria are met:

(a) Only once per client every six months within a twelve-month period.

(b) Only when not performed on the same date of service as prophylaxis or within six months from a prophylaxis by the same provider or clinic.

(c) Only when provided by a licensed dentist or a licensed dental hygienist and the instruction is provided in a setting other than a dental office or clinic.

(5) ((~~**Tobacco/nicotine cessation counseling for the control and prevention of oral disease.** The agency covers tobacco/nicotine cessation counseling for pregnant women only. See WAC 182-531-1720.~~

~~(6)~~)) **Sealants.** The agency covers:

(a) Sealants for clients age twenty and younger and clients any age of the developmental disabilities administration of DSHS.

(b) ((~~Sealants, other than glass ionomer cement, only when used on a mechanically or chemically prepared enamel surface.~~

~~(c)~~)) Sealants once per tooth:

(i) In a three-year period for clients age twenty and younger; and

(ii) In a two-year period for clients any age of the developmental disabilities administration of DSHS according to WAC 182-535-1099.

(((~~(d)~~)) (c) Sealants only when used on the occlusal surfaces of:

(i) Permanent teeth two, three, fourteen, fifteen, eighteen, nineteen, thirty, and thirty-one; and

(ii) Primary teeth A, B, I, J, K, L, S, and T.

(((~~(e)~~)) (d) Sealants on noncarious teeth or teeth with incipient caries.

(((~~(f)~~)) (e) Sealants only when placed on a tooth with no preexisting occlusal restoration, or any occlusal restoration placed on the same day.

(((~~(g)~~)) (f) Sealants are included in the agency's payment for occlusal restoration placed on the same day.

(((~~(h)~~)) (g) Additional sealants not described in this subsection on a case-by-case basis and when prior authorized.

(((~~(7)~~)) (6) **Space maintenance.** The agency covers:

(a) One fixed unilateral space maintainer per quadrant or one fixed bilateral space maintainer per arch, including recementation, for missing primary molars A, B, I, J, K, L, S, and T, when:

(i) Evidence of pending permanent tooth eruption exists; and

(ii) The service is not provided during approved orthodontic treatment.

(b) Replacement space maintainers on a case-by-case basis when authorized.

(c) The removal of fixed space maintainers when removed by a different provider.

(i) Space maintainer removal is allowed once per appliance.

(ii) Reimbursement for space maintainer removal is included in the payment to the original provider that placed the space maintainer.

AMENDATORY SECTION (Amending WSR 19-09-058, filed 4/15/19, effective 7/1/19)

WAC 182-535-1084 Dental-related services—Covered—Restorative services. Clients described in WAC 182-535-1060 are eligible for the dental-related restorative services listed in this section, subject to coverage limitations, restrictions, and client age requirements identified for a specific service.

(1) **Amalgam ((~~and~~)), resin, and glass ionomer restorations for primary and permanent teeth.** The medicaid agency considers:

(a) Tooth preparation, acid etching, all adhesives (including bonding agents), liners and bases, indirect and direct pulp capping, polishing, and curing as part of the restoration.

(b) Occlusal adjustment of either the restored tooth or the opposing tooth or teeth as part of the restoration.

(c) Restorations placed within six months of a crown preparation by the same provider or clinic to be included in the payment for the crown.

(2) **Limitations for all restorations.** The agency:

(a) Considers multiple restoration involving the proximal and occlusal surfaces of the same tooth as a multisurface restoration, and limits reimbursement to a single multisurface restoration.

(b) Considers multiple restorative resins, flowable composite resins, ((~~or~~)) resin-based composites, or glass ionomer restorations for the occlusal, buccal, lingual, mesial, and distal fissures and grooves on the same tooth as a one-surface restoration.

(c) Considers multiple restorations of fissures and grooves of the occlusal surface of the same tooth as a one-surface restoration.

(d) Considers resin-based composite restorations of teeth where the decay does not penetrate the dentinoenamel junction (DEJ) to be sealants. (See WAC 182-535-1082 for sealant coverage.)

(e) ((~~Reimburses proximal restorations that do not involve the incisal angle on anterior teeth as a two-surface restoration.~~

~~(f)~~)) Covers only one buccal and one lingual surface per tooth. The agency reimburses buccal or lingual restorations, regardless of size or extension, as a one-surface restoration.

(((~~g) Does not cover preventive restorative resin or flowable composite resin on the interproximal surfaces (mesial or distal) when performed on posterior teeth or the incisal surface of anterior teeth.~~

~~(h) Does not pay for replacement restorations within a two-year period unless the restoration is cracked or broken or has an additional adjoining carious surface. The agency pays for the replacement restoration as one multisurface restoration.~~)) (f) Does not cover preventative restorations.

(g) Covers replacement restorations between six and twenty-four months of original placement, with approved prior authorization, if the restoration is cracked or broken. The client's record must include X-rays or documentation supporting the medical necessity for the replacement restoration.

(h) Replacement of a cracked or broken restoration within a six-month period by the same provider is considered part of the global payment of the initial restoration and will not pay separately.

(3) ((~~**Additional limitations for restorations on primary teeth.** The agency covers:~~

~~(a) A maximum of two surfaces for a primary first molar. (See subsection (6) of this section for a primary first molar that requires a restoration with three or more surfaces.) The agency does not pay for additional restorations on the same tooth.~~

~~(b) A maximum of three surfaces for a primary second molar. (See subsection (6) of this section for a primary posterior tooth that requires a restoration with four or more surfaces.) The agency does not pay for additional restorations on the same tooth.~~

~~(c) A maximum of three surfaces for a primary anterior tooth. (See subsection (6) of this section for a primary anterior tooth that requires a restoration with four or more surfaces.) The agency does not pay for additional restorations on the same tooth after three surfaces.~~

~~(4)~~)) **Additional limitations for restorations on permanent teeth.** The agency covers:

(a) Two occlusal restorations for the upper molars on teeth one, two, three, fourteen, fifteen, and sixteen if, the restorations are anatomically separated by sound tooth structure.

(b) A maximum of five surfaces per tooth for permanent posterior teeth, except for upper molars. The agency allows a maximum of six surfaces per tooth for teeth one, two, three, fourteen, fifteen, and sixteen.

(c) A maximum of six surfaces per tooth for resin-based composite restorations for permanent anterior teeth.

(((~~5~~))) (4) **Crowns.** The agency:

(a) Covers the following indirect crowns once every five years, per tooth, for permanent anterior teeth for clients age fifteen through twenty when the crowns meet prior authorization criteria in WAC 182-535-1220 and the provider follows the prior authorization requirements in (c) of this subsection:

(i) Porcelain/ceramic crowns to include all porcelains, glasses, glass-ceramic, and porcelain fused to metal crowns; and

(ii) Resin crowns and resin metal crowns to include any resin-based composite, fiber, or ceramic reinforced polymer compound.

(b) Considers the following to be included in the payment for a crown:

(i) Tooth and soft tissue preparation;

(ii) Amalgam and resin-based composite restoration, or any other restorative material placed within six months of the crown preparation. Exception: The agency covers a one-surface restoration on an endodontically treated tooth, or a core buildup or cast post and core;

(iii) Temporaries((~~,~~)) including, but not limited to, temporary restoration, temporary crown, provisional crown, temporary prefabricated stainless steel crown, ion crown, or acrylic crown;

(iv) Packing cord placement and removal;

(v) Diagnostic or final impressions;

(vi) Crown seating (placement), including cementing and insulating bases;

(vii) Occlusal adjustment of crown or opposing tooth or teeth; and

(viii) Local anesthesia.

(c) Requires the provider to submit the following with each prior authorization request:

(i) Radiographs to assess all remaining teeth;

(ii) Documentation and identification of all missing teeth;

(iii) Caries diagnosis and treatment plan for all remaining teeth, including a caries control plan for clients with rampant caries;

(iv) Pre- and post-endodontic treatment radiographs for requests on endodontically treated teeth; and

(v) Documentation supporting a five-year prognosis that the client will retain the tooth or crown if the tooth is crowned.

(d) Requires a provider to bill for a crown only after delivery and seating of the crown, not at the impression date.

(((~~(6)~~))) (5) **Other restorative services.** The agency covers the following restorative services:

(a) All recementations of permanent indirect crowns.

(b) Prefabricated stainless steel crowns, including stainless steel crowns with resin window, resin-based composite crowns (direct), prefabricated esthetic coated stainless steel crowns, and prefabricated resin crowns for primary anterior teeth once every three years only for clients age twenty and younger ((~~as follows:~~

~~(i) For age twelve and younger without prior authorization if the tooth requires a four or more surface restoration; and~~

~~(ii) For age thirteen through twenty with prior authorization~~)).

(c) Prefabricated stainless steel crowns, including stainless steel crowns with resin window, resin-based composite crowns (direct), prefabricated esthetic coated stainless steel crowns, and prefabricated resin crowns, for primary posterior teeth once every three years without prior authorization for clients ages zero through twelve and with prior authorization for clients age thirteen through twenty if:

(i) ((~~Decay involves three or more surfaces for a primary first molar;~~

~~(ii) Decay involves four or more surfaces for a primary second molar; or~~

~~(iii)~~)) The tooth had a pulpotomy; or

(ii) Evidence of Class II caries with rampant decay; or

(iii) Evidence of extensive caries; or

(iv) Treatment of decay requires sedation or general anesthesia.

(d) Prefabricated stainless steel crowns, including stainless steel crowns with resin window, and prefabricated resin crowns, for permanent posterior teeth excluding one, sixteen, seventeen, and thirty-two once every three years, for clients age twenty and younger, without prior authorization.

(e) Prefabricated stainless steel crowns, for permanent posterior teeth, excluding one, sixteen, seventeen, and thirty-two for clients age twenty-one and older in lieu of a restoration requiring three or more surfaces.

(f) Prefabricated stainless steel crowns for clients of the developmental disabilities administration of the department of social and health services (DSHS) without prior authorization ((~~according to~~)) in accordance with WAC 182-535-1099.

(((~~f~~))) (g) Core buildup, including pins, only on permanent teeth, only for clients age twenty and younger, and only allowed in conjunction with crowns and when prior authorized. For indirect crowns, prior authorization must be obtained from the agency at the same time as the crown. Providers must submit pre- and post-endodontic treatment radiographs to the agency with the authorization request for endodontically treated teeth.

(((~~g~~))) (h) Cast post and core or prefabricated post and core, only on permanent teeth, only for clients age twenty and younger, and only when in conjunction with a crown and when prior authorized.

AMENDATORY SECTION (Amending WSR 18-04-028, filed 1/30/18, effective 3/2/18)

WAC 182-535-1090 Dental-related services—Covered—Prosthodontics (removable). Clients described in WAC 182-535-1060 are eligible to receive the prosthodontics (removable) and related services, subject to the coverage limitations, restrictions, and client-age requirements identified for a specific service.

(1) **Prosthodontics.** The medicaid agency requires prior authorization for removable prosthodontic and prosthodontic-related procedures, except as otherwise noted in this section. Prior authorization requests must meet the criteria in WAC 182-535-1220. In addition, the agency requires the dental provider to submit:

(a) Appropriate and diagnostic radiographs of all remaining teeth.

(b) A dental record which identifies:

(i) All missing teeth for both arches;

(ii) Teeth that are to be extracted; and

(iii) Dental restorative and periodontal services completed on all remaining teeth in the arch(es) being requested.

(2) **Complete dentures.** The agency covers complete dentures, including overdentures, when prior authorized, except as otherwise noted in this section.

The agency considers three-month post-delivery care (e.g., adjustments, soft relines, and repairs) from the delivery (placement) date of the complete denture as part of the complete denture procedure and does not pay separately for this care.

(a) The agency covers complete dentures only as follows:

(i) One initial maxillary complete denture and one initial mandibular complete denture per client.

(ii) Replacement of a partial denture with a complete denture only when the replacement occurs three or more years after the delivery (placement) date of the last resin partial denture.

(iii) One replacement maxillary complete denture and one replacement mandibular complete denture per client, per client's lifetime. The replacement must occur at least five years after the delivery (placement) date of the initial complete denture or overdenture((~~. The replacement does not require prior authorization~~)) and the replacement is medically necessary. Prior authorization is required for all replacement dentures with evidence of medical necessity.

(b) The agency reviews requests for replacement that exceed the limits in this subsection (2) under WAC 182-501-0050(7).

(c) The provider must obtain a current signed Denture Agreement of Acceptance (HCA 13-809) form from the client at the conclusion of the final denture try-in and at the time of delivery for an agency-authorized complete denture. If the client abandons the complete denture after signing the agreement of acceptance, the agency will deny subsequent requests for the same type of dental prosthesis if the request occurs prior to the dates specified in this section. A copy of the signed agreement must be kept in the provider's files and be available upon request by the agency. Failure to submit the completed, signed Denture Agreement of Acceptance form

when requested may result in recoupment of the agency's payment.

(3) **Resin partial dentures.** The agency covers resin partial dentures only as follows:

(a) For anterior and posterior teeth only when the following criteria are met:

(i) The remaining teeth in the arch must be ((~~free of periodontal disease~~)) periodontally stable and have a reasonable periodontal prognosis.

(ii) The client has established caries control.

(iii) The client has one or more missing anterior teeth or four or more missing posterior teeth (excluding teeth one, two, fifteen, and sixteen) on the upper arch to qualify for a maxillary partial denture. Pontics on an existing fixed bridge do not count as missing teeth. The agency does not consider closed spaces of missing teeth to qualify as a missing tooth.

(iv) The client has one or more missing anterior teeth or four or more missing posterior teeth (excluding teeth seventeen, eighteen, thirty-one, and thirty-two) on the lower arch to qualify for a mandibular partial denture. Pontics on an existing fixed bridge do not count as missing teeth. The agency does not consider closed spaces of missing teeth to qualify as a missing tooth.

(v) There is a minimum of four functional, stable teeth remaining per arch.

(vi) There is a three-year prognosis for retention of the remaining teeth.

(b) Prior authorization is required.

(c) The agency considers three-month post-delivery care (e.g., adjustments, soft relines, and repairs) from the delivery (placement) date of the resin partial denture as part of the resin partial denture procedure and does not pay separately for this care.

(d) Replacement of a resin-based partial denture with a new resin partial denture or a complete denture if it occurs at least three years after the delivery (placement) date of the resin-based partial denture((~~. The replacement partial or complete denture must be prior authorized~~)) and is medically necessary. Prior authorization is required for all replacement dentures with evidence of medical necessity and meet agency coverage criteria in (a) of this subsection.

(e) The agency reviews requests for replacement that exceed the limits in this subsection (3) under WAC 182-501-0050(7).

(f) The provider must obtain a signed Partial Denture Agreement of Acceptance (HCA 13-965) form from the client at the time of delivery for an agency-authorized partial denture. A copy of the signed agreement must be kept in the provider's files and be available upon request by the agency. Failure to submit the completed, signed Partial Denture Agreement of Acceptance form when requested may result in recoupment of the agency's payment.

(4) **Provider requirements.**

(a) The agency requires a provider to bill for a removable partial or complete denture only after the delivery of the prosthesis, not at the impression date. Refer to subsection (5)(e) of this section for what the agency may pay if the removable partial or complete denture is not delivered and inserted.

(b) The agency requires a provider to submit the following with a prior authorization request for a removable resin partial or complete denture for a client residing in an alternate living facility or nursing facility:

(i) The client's medical diagnosis or prognosis;

(ii) The attending physician's request for prosthetic services;

(iii) The attending dentist's or denturist's statement documenting medical necessity;

(iv) A written and signed consent for treatment from the client's legal guardian when a guardian has been appointed; and

(v) A completed copy of the Denture/Partial Appliance Request for Skilled Nursing Facility Client (HCA 13-788) form available from the agency's published billing instructions which can be downloaded from the agency's website.

(c) The agency limits removable partial dentures to resin-based partial dentures for all clients residing in one of the facilities listed in (b) of this subsection.

(d) The agency requires a provider to deliver services and procedures that are of acceptable quality to the agency. The agency may recoup payment for services that are determined to be below the standard of care or of an unacceptable product quality.

(5) **Other services for removable prosthodontics.** The agency covers:

(a) Adjustments to complete and partial dentures three months after the date of delivery.

(b) Repairs:

(i) To complete dentures, once in a twelve-month period, per arch. The cost of repairs cannot exceed the cost of the replacement denture. The agency covers additional repairs on a case-by-case basis and when prior authorized.

(ii) To partial dentures, once in a twelve-month period, per arch. The cost of the repairs cannot exceed the cost of the replacement partial denture. The agency covers additional repairs on a case-by-case basis and when prior authorized.

(c) A laboratory reline or rebase to a complete or partial denture, once in a three-year period when performed at least six months after the delivery (placement) date. The agency does not pay for a denture reline and a rebase in the same three-year period. An additional reline or rebase may be covered for complete or partial dentures on a case-by-case basis when prior authorized.

(d) Laboratory fees, subject to the following:

(i) The agency does not pay separately for laboratory or professional fees for complete and partial dentures; and

(ii) The agency may pay part of billed laboratory fees when the provider obtains prior authorization, and the client:

(A) Is not eligible at the time of delivery of the partial or complete denture;

(B) Moves from the state;

(C) Cannot be located;

(D) Does not participate in completing the partial or complete denture; or

(E) Dies.

(iii) A provider must submit copies of laboratory prescriptions and receipts or invoices for each claim when billing for laboratory fees.

AMENDATORY SECTION (Amending WSR 19-06-003, filed 2/21/19, effective 3/24/19)

WAC 182-535-1094 Dental-related services—Covered—Oral and maxillofacial surgery services. Clients described in WAC 182-535-1060 are eligible to receive the oral and maxillofacial surgery services listed in this section, subject to the coverage limitations, restrictions, and client-age requirements identified for a specific service.

(1) **Oral and maxillofacial surgery services.** The medicaid agency:

(a) Requires enrolled providers who do not meet the conditions in WAC 182-535-1070(3) to bill claims for services that are listed in this subsection using only the current dental terminology (CDT) codes.

(b) Requires enrolled providers (oral and maxillofacial surgeons) who meet the conditions in WAC 182-535-1070(3) to bill claims using current procedural terminology (CPT) codes unless the procedure is specifically listed in the agency's current published billing guide as a CDT covered code (e.g., extractions).

(c) Covers nonemergency oral surgery performed in a hospital or ambulatory surgery center only for:

(i) Clients age eight and younger;

(ii) Clients age nine through twenty. Prior authorization is required for the site of service; and

(iii) Clients any age of the developmental disabilities administration of the department of social and health services (DSHS).

(d) For site-of-service and oral surgery CPT codes that require prior authorization, the agency requires the dental provider to submit current records (within the past twelve months), including:

(i) Documentation used to determine medical appropriateness;

(ii) Cephalometric films;

(iii) Radiographs (X-rays);

(iv) Photographs; and

(v) Written narrative/letter of medical necessity, including proposed billing codes.

(e) Requires the client's dental record to include supporting documentation for each type of extraction or any other surgical procedure billed to the agency. The documentation must include:

(i) Appropriate consent form signed by the client or the client's legal representative;

(ii) Appropriate radiographs;

(iii) Medical justification with diagnosis;

(iv) Client's blood pressure, when appropriate;

(v) A surgical narrative and complete description of each service performed beyond surgical extraction or beyond code definition;

(vi) A copy of the post-operative instructions; and

(vii) A copy of all pre- and post-operative prescriptions.

(f) Covers simple and surgical extractions.

(g) Covers unusual, complicated surgical extractions with prior authorization.

(h) Covers tooth reimplantation/stabilization of accidentally evulsed or displaced teeth.

(i) Covers surgical extraction of unerupted teeth ((~~for clients~~)).

(j) Covers debridement of a granuloma or cyst that is five millimeters or greater in diameter. The agency includes debridement of a granuloma or cyst that is less than five millimeters as part of the global fee for the extraction.

(k) Covers biopsy of soft oral tissue, brush biopsy, and surgical excision of soft tissue lesions. Providers must keep all biopsy reports or findings in the client's dental record.

(l) Covers only the following excisions of bone tissue in conjunction with placement of complete or partial dentures:

(i) Removal of lateral exostosis;

(ii) Removal of torus palatinus or torus mandibularis;

(iii) Surgical reduction of osseous tuberosity.

(2) **Alveoloplasty.** The agency covers alveoloplasty((~~. Prior authorization is not required~~)) only in conjunction with the preparation of dentures or partials. Documentation supporting the medical necessity for the procedure must be maintained in the client's record. Supporting documentation must include current radiographs and medical justification narrative.

(3) **Surgical incisions.** The agency covers the following surgical incision-related services:

(a) Uncomplicated intraoral and extraoral soft tissue incision and drainage of abscess. The agency does not cover this service when combined with an extraction or root canal treatment. Documentation supporting the medical necessity must be in the client's record.

(b) Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue. Documentation supporting the medical necessity for the service must be in the client's record.

(c) Frenuloplasty/frenulectomy for clients age six and younger, without prior authorization.

(d) Frenuloplasty/frenulectomy for clients age seven through twelve. Prior authorization is required. Photos must be submitted to the agency with the prior authorization request. Documentation supporting the medical necessity for the service must be in the client's record.

(e) Surgical access of unerupted teeth for clients age twenty and younger. Prior authorization is required.

(4) **Occlusal orthotic devices.** (Refer to WAC 182-535-1098 (4)(c) for occlusal guard coverage and limitations on coverage.) The agency covers:

(a) Occlusal orthotic devices for clients age twelve through twenty. Prior authorization is required.

(b) An occlusal orthotic device only as a laboratory processed full arch appliance.

AMENDATORY SECTION (Amending WSR 20-08-103, filed 3/30/20, effective 4/30/20)

WAC 182-535-1098 Covered—Adjunctive general services. Clients described in WAC 182-535-1060 are eligible to receive the adjunctive general services listed in this section, subject to coverage limitations, restrictions, and client-age requirements identified for a specific service.

(1) **Adjunctive general services.** The medicaid agency:

(a) Covers palliative (emergency) treatment, not to include pupal debridement (see WAC 182-535-1086 (2)(b)), for treatment of dental pain, limited to once per day, per client, as follows:

(i) The treatment must occur during limited evaluation appointments;

(ii) A comprehensive description of the diagnosis and services provided must be documented in the client's record; and

(iii) Appropriate radiographs must be in the client's record supporting the medical necessity of the treatment.

(b) Covers local anesthesia and regional blocks as part of the global fee for any procedure being provided to clients.

(c) Covers office-based deep sedation/general anesthesia services:

(i) For all eligible clients age eight and younger and clients any age of the developmental disabilities administration of the department of social and health services (DSHS). Documentation supporting the medical necessity of the anesthesia service must be in the client's record.

(ii) For clients age nine through twenty on a case-by-case basis and when prior authorized, except for oral surgery services. For oral surgery services listed in WAC 182-535-1094 (1)(f) through (((~~(m)~~)) (l) and clients with cleft palate diagnoses, the agency does not require prior authorization for deep sedation/general anesthesia services.

(iii) For clients age twenty-one and older when prior authorized. The agency considers these services for only those clients:

(A) With medical conditions such as tremors, seizures, or asthma;

(B) Whose records contain documentation of tried and failed treatment under local anesthesia or other less costly sedation alternatives due to behavioral health conditions; or

(C) With other conditions for which general anesthesia is medically necessary, as defined in WAC 182-500-0070.

(d) Covers office-based intravenous moderate (conscious) sedation/analgesia:

(i) For any dental service for clients age twenty and younger, and for clients any age of the developmental disabilities administration of DSHS. Documentation supporting the medical necessity of the service must be in the client's record.

(ii) For clients age twenty-one and older when prior authorized. The agency considers these services for only those clients:

(A) With medical conditions such as tremors, seizures, or asthma;

(B) Whose records contain documentation of tried and failed treatment under local anesthesia, or other less costly sedation alternatives due to behavioral health conditions; or

(C) With other conditions for which general anesthesia or conscious sedation is medically necessary, as defined in WAC 182-500-0070.

(e) Covers office-based nonintravenous conscious sedation:

(i) For any dental service for clients age twenty and younger, and for clients any age of the developmental disabilities administration of DSHS. Documentation supporting the medical necessity of the service must be in the client's record.

(ii) For clients age twenty-one and older, only when prior authorized.

(f) Requires providers to bill anesthesia services using the current dental terminology (CDT) codes listed in the agency's current published billing instructions.

(g) Requires providers to have a current anesthesia permit on file with the agency.

(h) Covers administration of nitrous oxide once per day, per client per provider.

(i) Requires providers of oral or parenteral conscious sedation, deep sedation, or general anesthesia to meet:

(i) The prevailing standard of care;

(ii) The provider's professional organizational guidelines;

(iii) The requirements in chapter 246-817 WAC; and

(iv) Relevant department of health (DOH) medical, dental, or nursing anesthesia regulations.

(j) Pays for dental anesthesia services according to WAC 182-535-1350.

(k) Covers professional consultation/diagnostic services as follows:

(i) A dentist or a physician other than the practitioner providing treatment must provide the services; and

(ii) A client must be referred by the agency for the services to be covered.

(2) **Professional visits.** The agency covers:

(a) Up to two house/extended care facility calls (visits) per facility, per provider. The agency limits payment to two facilities per day, per provider.

(b) One hospital visit, including emergency care, per day, per provider, per client, and not in combination with a surgical code unless the decision for surgery is a result of the visit.

(c) Emergency office visits after regularly scheduled hours. The agency limits payment to one emergency visit per day, per client, per provider.

(3) **Drugs and medicaments (pharmaceuticals).**

(a) The agency covers oral sedation medications only when prescribed and the prescription is filled at a pharmacy. The agency does not cover oral sedation medications that are dispensed in the provider's office for home use.

(b) The agency covers therapeutic parenteral drugs as follows:

(i) Includes antibiotics, steroids, anti-inflammatory drugs, or other therapeutic medications. This does not include sedative, anesthetic, or reversal agents.

(ii) Only one single-drug injection or one multiple-drug injection per date of service.

(c) For clients age twenty and younger, the agency covers other drugs and medicaments dispensed in the provider's office for home use. This includes, but is not limited to, oral antibiotics and oral analgesics. The agency does not cover the time spent writing prescriptions.

(d) For clients enrolled in an agency-contracted managed care organization (MCO), the client's MCO pays for dental prescriptions.

(4) **Miscellaneous services.** The agency covers:

(a) Behavior management provided by a dental provider or clinic. The agency does not cover assistance with managing a client's behavior provided by a dental provider or staff member delivering the client's dental treatment.

(i) Documentation supporting the need for behavior management must be in the client's record and including the following:

(A) A description of the behavior to be managed;

(B) The behavior management technique used; and

(C) The identity of the additional professional staff used to provide the behavior management.

(ii) Clients, who meet one of the following criteria and whose documented behavior requires the assistance of one additional professional staff employed by the dental provider or clinic to protect the client and the professional staff from injury while treatment is rendered, may receive behavior management:

(A) Clients age eight and younger;

(B) Clients age nine through twenty, only on a case-by-case basis and when prior authorized;

(C) Clients any age of the developmental disabilities administration of DSHS;

(D) Clients diagnosed with autism;

(E) Clients who reside in an alternate living facility (ALF) as defined in WAC 182-513-1301, or in a nursing facility as defined in WAC 182-500-0075.

(iii) Behavior management can be performed in the following settings:

(A) Clinics (including independent clinics, tribal health clinics, federally qualified health centers, rural health clinics, and public health clinics);

(B) Offices;

(C) Homes (including private homes and group homes); and

(D) Facilities (including nursing facilities and alternate living facilities).

(b) Treatment of post-surgical complications (e.g., dry socket). Documentation supporting the medical necessity of the service must be in the client's record.

(c) Occlusal guards when medically necessary and prior authorized. (Refer to WAC 182-535-1094(3) for occlusal orthotic device coverage and coverage limitations.) The agency covers:

(i) An occlusal guard only for clients age twelve through twenty when the client has permanent dentition; and

(ii) An occlusal guard only as a laboratory processed full arch appliance.

(5) **Nonclinical procedures.**

(a) The agency covers teledentistry according to the department of health, health systems quality assurance office of health professions, current guidelines, appropriate use of teledentistry, and as follows (see WAC 182-531-1730 for coverage limitations not listed in this section):

(i) Synchronous teledentistry at the distant site for clients of all ages; and

(ii) Asynchronous teledentistry at the distant site for clients of all ages.

(b) The client's record must include the following supporting documentation regarding teledentistry:

(i) Service provided via teledentistry;

(ii) Location of the client;

(iii) Location of the provider; and

(iv) Names and credentials of all persons involved in the teledentistry visit and their role in providing the service at both the originating and distant sites.

AMENDATORY SECTION (Amending WSR 17-20-097, filed 10/3/17, effective 11/3/17)

WAC 182-535-1099 Dental-related services for clients of the developmental disabilities administration of the department of social and health services. Subject to coverage limitations and restrictions identified for a specific service, the medicaid agency pays for the additional dental-related services listed in this section that are provided to clients of the developmental disabilities administration of the department of social and health services (DSHS), regardless of age.

(1) **Preventive services.** The agency covers:

(a) Periodic oral evaluations once every four months per client, per provider.

(b) Prophylaxis once every four months.

(c) Periodontal maintenance once every six months (see subsection (3) of this section for limitations on periodontal scaling and root planing).

(d) Topical fluoride varnish, rinse, foam or gel, once every four months, per client, per provider or clinic.

(e) Sealants (see WAC 182-535-1082 for sealant coverage):

(i) Only when used on the occlusal surfaces of:

(A) Primary teeth A, B, I, J, K, L, S, and T; or

(B) Permanent teeth two, three, four, five, twelve, thirteen, fourteen, fifteen, eighteen, nineteen, twenty, twenty-one, twenty-eight, twenty-nine, thirty, and thirty-one.

(ii) Once per tooth in a two-year period.

(2) **Other restorative services.** The agency covers:

(a) All recementations of permanent indirect crowns.

(b) Prefabricated stainless steel crowns, including stainless steel crowns with resin window, resin-based composite crowns (direct), prefabricated esthetic coated stainless steel crowns, and prefabricated resin crowns for primary anterior teeth once every two years only for clients age twenty and younger without prior authorization.

(c) Prefabricated stainless steel crowns, including stainless steel crowns with resin window, resin-based composite crowns (direct), prefabricated esthetic coated stainless steel crowns, and prefabricated resin crowns for primary posterior teeth once every two years for clients age twenty and younger without prior authorization if:

(i) Decay involves three or more surfaces for a primary first molar;

(ii) Decay involves four or more surfaces for a primary second molar; or

(iii) The tooth had a pulpotomy.

(d) Prefabricated stainless steel crowns, including stainless steel crowns with resin window, and prefabricated resin crowns for permanent posterior teeth excluding one, sixteen, seventeen, and thirty-two once every two years without prior authorization for any age.

(3) **Periodontic services.**

(a) **Surgical periodontal services.** The agency covers:

(i) Gingivectomy/gingivoplasty once every three years. Documentation supporting the medical necessity of the service must be in the client's record (e.g., drug induced gingival hyperplasia).

(ii) Gingivectomy/gingivoplasty with periodontal scaling and root planing or periodontal maintenance when the services are performed:

(A) In a hospital or ambulatory surgical center; or

(B) For clients under conscious sedation, deep sedation, or general anesthesia.

(b) **Nonsurgical periodontal services.** The agency covers:

(i) Periodontal scaling and root planing, one time per quadrant in a twelve-month period.

(ii) Periodontal maintenance (four quadrants) substitutes for an eligible periodontal scaling or root planing, twice in a twelve-month period.

(iii) Periodontal maintenance allowed six months after scaling or root planing.

(iv) Full-mouth or quadrant debridement allowed once in a twelve-month period.

(v) Full-mouth scaling in the presence of generalized moderate or severe gingival inflammation allowed once in a twelve-month period.

(4) **Adjunctive general services.** The agency covers:

(a) Oral parenteral conscious sedation, deep sedation, or general anesthesia for any dental services performed in a dental office or clinic. Documentation supporting the medical necessity must be in the client's record.

(b) Sedation services according to WAC 182-535-1098 (1)(c) and (e).

(5) **Nonemergency dental services.** The agency covers nonemergency dental services performed in a hospital or an ambulatory surgical center for services listed as covered in WAC 182-535-1082, 182-535-1084, 182-535-1086, 182-535-1088, and 182-535-1094. Documentation supporting the medical necessity of the service must be included in the client's record.

(6) **Miscellaneous services - Behavior management.** The agency covers behavior management according to WAC 182-535-1098.

AMENDATORY SECTION (Amending WSR 17-20-097, filed 10/3/17, effective 11/3/17)

WAC 182-535-1220 Obtaining prior authorization for dental-related services. (1) The medicaid agency uses the determination process for payment described in WAC 182-501-0165 for covered dental-related services that require prior authorization.

(2) The agency requires a dental provider who is requesting prior authorization to submit sufficient, current (within the past twelve months), objective clinical information to establish medical necessity. The request must be submitted in writing on the General Information for Authorization (HCA 13-835) form, available on the agency's website.

(3) The agency may request additional information as follows:

(a) Additional radiographs (X-rays) (refer to WAC 182-535-1080(2));

(b) ((~~Study models;~~

~~(c)~~)) Photographs; and

(((~~(d)~~))) (c) Any other information as determined by the agency.

(4) The agency may require second opinions and/or consultations by a licensed independent doctor of dental surgery (DDS)/doctor of ((~~dental medicine~~)) medicine in dentistry (DMD) before authorizing any procedure.

(5) When the agency authorizes a dental-related service for a client, that authorization indicates only that the specific service is medically necessary; it is not a guarantee of payment. The authorization is valid for six to twelve months as indicated in the agency's authorization letter and only if the client is eligible for covered services on the date of service.

(6) The agency denies a request for a dental-related service when the requested service:

(a) Is covered by another state agency program;

(b) Is covered by an entity outside the agency; or

(c) Fails to meet the program criteria, limitations, or restrictions in this chapter.

AMENDATORY SECTION (Amending WSR 20-04-096, filed 2/5/20, effective 3/7/20)

WAC 182-535-1245 Access to baby and child dentistry (ABCD) program. The access to baby and child dentistry (ABCD) program is a program established to increase access to dental services for medicaid-eligible clients ages five and younger.

(1) Client eligibility for the ABCD program is as follows:

(a) Clients must be age five and younger. Once enrolled in the ABCD program, eligible clients are covered until their sixth birthday.

(b) Clients eligible under one of the following medical assistance programs are eligible for the ABCD program:

(i) Categorically needy program (CNP);

(ii) Limited casualty program-medically needy program (LCP-MNP);

(iii) Children's health program; or

(iv) State children's health insurance program (SCHIP).

(c) ABCD program services provided by a dental provider for eligible clients who are enrolled in an agency-contracted managed care organization (MCO) are paid through the fee-for-service payment system.

(d) ABCD program services provided by a ((~~nondental~~)) medical provider for eligible clients who are enrolled in an agency-contracted managed care organization (MCO) must be billed directly through the client's MCO.

(2) Health care providers and community service programs identify and refer eligible clients to the ABCD program. If enrolled, the client and an adult family member may receive:

(a) Oral health education;

(b) "Anticipatory guidance" (expectations of the client and the client's family members, including the importance of keeping appointments); and

(c) Assistance with transportation, interpreter services, and other issues related to dental services.

(3) Only ABCD-certified dentists and other agency-approved certified providers are paid an enhanced fee for furnishing ABCD program services. ABCD program services include, when appropriate:

(a) Family oral health education. An oral health education visit:

(i) Is limited to one visit per day per family, up to two visits per child in a twelve-month period, per provider or clinic; and

(ii) Must include documentation ((~~of all~~)) of the following in the client's record:

(A) "Lift the lip" training;

(B) Oral hygiene training;

(C) Risk assessment for early childhood caries;

(D) Dietary counseling;

(E) Discussion of fluoride supplements; and

(F) Documentation in the client's record to record the activities provided ((~~and duration of~~)) at the oral education visit.

(b) Comprehensive oral evaluations as defined in WAC 182-535-1050, once per client, per provider or clinic, as an initial examination. The agency covers an additional comprehensive oral evaluation if the client has not been treated by the same provider or clinic within the past five years;

(c) Periodic oral evaluations as defined in WAC 182-535-1050, once every six months. Six months must elapse between the comprehensive oral evaluation and the first periodic oral evaluation;

(d) Topical application of fluoride varnish;

(e) Amalgam, resin, and glass ionomer restorations on primary teeth, as specified in the agency's current published documents;

(f) Interim therapeutic restorations (ITRs) for primary teeth, only for clients age five and younger. The agency pays an enhanced rate for these restorations to ABCD-certified, ITR-trained dentists as follows:

(i) A one-surface, resin-based composite, or glass ionomer restoration with a maximum of five teeth per visit; and

(ii) Restorations on a tooth can be done every twelve months through age five, or until the client can be definitively treated for a restoration.

(g) Therapeutic pulpotomy;

(h) Prefabricated stainless steel crowns on primary teeth, as specified in the agency's current published documents;

(i) Resin-based composite crowns on anterior primary teeth; and

(j) Other dental-related services, as specified in the agency's current published documents.

(4) The client's record must show documentation of the ABCD program services provided.