WSR 24-18-003
PERMANENT RULES
DEPARTMENT OF LICENSING
[Filed August 21, 2024, 5:04 p.m., effective September 21, 2024]

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

Purpose: To establish business and professional license requirements per ESHB 2153, passed during the 2024 legislative session. These rules clarify that vehicle wreckers and scrap metal businesses must pay a $500 Washington state patrol inspection fee when applying for an original or renewed license.

Citation of Rules Affected by this Order: Amending WAC 308-63-040 and 308-70-130.

Statutory Authority for Adoption: RCW 46.01.011 Purpose, 46.80.040 Issuance of license—Fee, 46.80.050 Expiration, renewal—Fee, 46.79.040 Application forwarded with fees—Issuance of license—Disposition of fees—Display of license, and 46.79.050 License expiration—Renewal fee—Surrender of license, when.

Adopted under notice filed as WSR 24-13-122 on June 20, 2024.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 2, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: August 21, 2024.

Ellis Starrett
Rules and Policy Manager

OTS-5515.1

AMENDATORY SECTION (Amending WSR 09-08-065, filed 3/27/09, effective 4/27/09)

WAC 308-63-040 Wreckers—Application for license. How must I apply for a vehicle wrecker license? An original or renewal application for a wrecker license must be filed with the director on the form provided by the department for this purpose. The application must be endorsed by the chief of police of any city with a population over ((~~five thousand~~)) 5,000; otherwise, by a member of the Washington state patrol. The endorsement certifies that the wrecker has an established place of business at the address shown on the application and that the applicant's vehicle(s) are properly identified in accordance with WAC 308-63-070(5). Applications for original or renewed licenses must include a $500 catalytic converter inspection fee for the purpose

of Washington state patrol inspections, in addition to all fees required under RCW 46.80.040 and 46.80.050.

Each application must specify the number of vehicles owned, leased, rented or otherwise operated by the applicant for towing or transportation of vehicles on public roadways in the conduct of the business. Each endorsement must identify the vehicle by make, model, year or other adequate description, and identification number.

OTS-5516.1

AMENDATORY SECTION (Amending WSR 22-24-039, filed 11/30/22, effective 12/31/22)

WAC 308-70-130 Fees. The following fees shall be charged by the department of licensing:

Processor and Recycler Application, Initial	$1,290.00
Processor and Recycler Application, Renewal	$665.00
Supplier Application, Initial	$390.00
Supplier Application, Renewal	$205.00
Catalytic Converter Inspection Fee, Initial	$500.00
Catalytic Converter Inspection Fee, Renewal	$500.00

WSR 24-18-006
PERMANENT RULES
DEPARTMENT OF HEALTH
[Filed August 22, 2024, 8:59 a.m., effective September 22, 2024]

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

Purpose: Kidney disease treatment center temporary emergency exemptions. The department of health (department) has adopted new WAC 246-310-825 Kidney disease treatment centers—Temporary emergency situation exemption, and amendments to existing kidney disease treatment center rules, WAC 246-310-800 through 246-310-806 and 246-310-812 through 246-310-833, to implement SSB 5569 (chapter 48, Laws of 2023), codified in RCW 70.38.280.

The department has also adopted amendments to address impacts to the need methodology based upon new temporary emergency situation exemption, as well as clean-up language to ensure consistency in kidney disease treatment center rules.

Citation of Rules Affected by this Order: New WAC 246-310-825; and amending WAC 246-310-800, 246-310-803, 246-310-806, 246-310-812, 246-310-815, 246-310-818, 246-310-821, 246-310-824, 246-310-827, 246-310-830, and 246-310-833.

Statutory Authority for Adoption: RCW 70.38.135; and SSB 5569 (chapter 48, Laws of 2023), codified at RCW 70.38.280.

Other Authority: RCW 70.38.280.

Adopted under notice filed as WSR 24-10-089 on April 30, 2024.

Changes Other than Editing from Proposed to Adopted Version: The department has updated references from "facility" to "center" in WAC 246-310-800 through 246-310-806 and 246-310-812 through 246-310-833 for consistency.

A final cost-benefit analysis is available by contacting Ross Valore, P.O. Box 47852, Olympia, WA 98504, phone 564-999-1060, TTY 711, email cnrulemaking@doh.wa.gov, website https://doh.wa.gov/licenses-permits-and-certificates/facilities-z/certificate-need.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 1, Amended 11, Repealed 0.

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

Number of Sections Adopted on the Agency's own Initiative: New 1, Amended 11, Repealed 0.

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

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 1, Amended 11, Repealed 0.

Date Adopted: August 21, 2024.

Kristin Peterson, JD
Chief of Policy
for Umair A. Shah, MD, MPH
Secretary

OTS-5242.4

AMENDATORY SECTION (Amending WSR 17-04-062, filed 1/27/17, effective 1/1/18)

WAC 246-310-800 Kidney disease treatment centers—Definitions. The definitions in this section apply to WAC 246-310-800 through 246-310-833, unless the context clearly indicates otherwise:

(1) "Affiliate" or "affiliated" means:

(a) Having at least a ((~~ten~~)) 10 percent but less than ((~~one hundred~~)) 100 percent ownership in a kidney ((~~dialysis facility~~)) disease treatment center;

(b) Having at least a ((~~ten~~)) 10 percent but less than ((~~one hundred~~)) 100 percent financial interest in a kidney ((~~dialysis facility~~)) disease treatment center; or

(c) Three years or more operational management responsibilities for a kidney ((~~dialysis facility~~)) disease treatment center.

(2) "Base year" means the most recent calendar year for which December 31st data is available as of the letter of intent submission date from the *((~~Northwest Renal~~)) Network's Modality Report*.

(3) "Capital expenditures," as defined by *Generally Accepted Accounting Principles* (GAAP), means expenditures made to acquire tangible long-lived assets. Long-lived assets represent property and equipment used in a company's operations that have an estimated useful life greater than one year. Acquired long-lived assets are recorded at acquisition cost and include all costs incurred necessary to bring the asset to working order. Capital expenditure includes:

(a) A force account expenditure or acquisition (i.e., an expenditure for a construction project undertaken by a ((~~facility~~)) center as its own contractor).

(b) The costs of any site planning services (architect or other site planning consultant) including, but not limited to, studies, surveys, designs, plans, working drawings, specifications, and other activities (including applicant staff payroll and employee benefit costs, consulting and other services which, under GAAP or Financial Accounting Standards Board (FASB) may be chargeable as an operating or nonoperating expense).

(c) Construction cost of shelled space.

(d) Building owner tenant improvements including, but not limited to: Asbestos removal, paving, concrete, contractor's general conditions, contractor's overhead and profit, electrical, heating, ventilation and air conditioning systems (HVAC), plumbing, flooring, rough and finish carpentry and millwork and associated labor and materials, and utility fees.

(e) Donations of equipment or facilities to a ((~~facility~~)) center.

(f) Capital expenditures do not include routine repairs and maintenance costs that do not add to the utility of useful life of the asset.

(4) "Concurrent review" means the process by which applications competing to provide services in the same planning area are reviewed simultaneously by the department.

(5) "Dialysis facility report (DFR)" means the kidney ((~~dialysis facility~~)) disease treatment center reports produced annually for Centers for Medicare and Medicaid Services (CMS). The DFR is provided to individual dialysis ((~~facilities~~)) centers and contains summary data on each ((~~facility~~)) center compiled from multiple sources. The DFR facilitates comparison of patient characteristics, treatment patterns,

transplantation rates, hospitalization rates, and mortality rates to local and national averages.

(6) "Dialysis facility compare (DFC) report" means the kidney dialysis facility compare quarterly report that is produced by CMS and posted on the medicare DFC website. This report provides information about statistically measurable practice patterns in kidney disease treatment ((~~facilities~~)) centers including, but not limited to, mortality, hospitalization, late shifts, and availability of home training.

(7) "End-of-year data" means data contained in the fourth quarter modality report or successor report from the ((~~Northwest Renal~~)) Network.

(8) "End-of-year in-center patients" means the number of in-center hemodialysis (HD) and self-dialysis training patients receiving in-center kidney dialysis at the end of the calendar year based on end-of-year data.

(9) "Exempt isolation station" means one certificate of need approved certified station per ((~~facility~~)) center dedicated to patients requiring medically necessary isolation. This station may not be used for nonisolation treatments. This one approved station is included in the kidney ((~~dialysis facility's~~)) disease treatment center's total CMS certified station count. However, for purposes of certificate of need, this one isolation station is not included in the ((~~facility's~~)) center's station count for projecting future station need or in calculating existing station use. Providers may operate more than one isolation station, but only one is excluded from the ((~~facility's~~)) center's station count for purposes of projecting future station need and in calculating existing station use.

(10) "Kidney disease treatment center" or "kidney dialysis facility" means any place, institution, building or agency or a distinct part thereof equipped and operated to provide services, including outpatient dialysis. In no case will all stations at a given kidney disease treatment center or kidney dialysis facility be designated as self-dialysis training stations. For purposes of these rules, kidney disease treatment center and kidney dialysis facility have the same meaning.

(11) "Maximum treatment floor area square footage" means the sum of (a), (b), (c), and (d) of this subsection:

(a) One hundred fifty square feet multiplied for each general use in-center station and each nonisolation station;

(b) Two hundred square feet multiplied for each isolation station and each permanent bed station as defined in subsection (14) of this section;

(c) Three hundred square feet for future expansion of two in-center treatment stations; and

(d) Other treatment floor space is ((~~seventy-five~~)) 75 percent of the sum of (a), (b), and (c) of this subsection.

As of the effective date of these rules, maximum treatment floor area square footage identified in a successful application cannot be used for future station expansion, except as provided in (c) of this subsection. For example, the applicant may use the maximum allowable treatment floor area square footage. The number of stations may include one isolation station, one permanent bed station, eight general use in-center stations, two future expansion stations, and maximum other treatment floor space. In this example, the total maximum treatment floor area square footage in this example would equal ((~~three thousand three hundred twenty-five~~)) 3,325 square feet.

(12) "Network" means end stage renal disease (ESRD) Network 16.

(13) "Operational" means the date when the kidney ((~~dialysis facility~~)) disease treatment center provides its first dialysis treatment in newly approved certificate of need stations, including relocated stations.

((~~(13)~~)) (14) "Patients per station" means the reported number of in-center patients at the kidney ((~~dialysis facility~~)) disease treatment center divided by counted certificate of need approved stations. The results are not rounded up. For example, 4.49 is not rounded to 4.5.

((~~(14)~~)) (15) "Permanent bed station" means a bed that would commonly be used in a health care setting.

((~~(15)~~)) (16) "Planning area" or "service area" means an individual geographic area designated by the department for which kidney dialysis station need projections are calculated. For purposes of kidney dialysis projects, planning area and service area have the same meaning. Each county is considered a separate planning area, except for the planning subareas identified for King, Snohomish, Pierce, and Spokane counties. If the United States Postal Service (USPS) changes zip codes in the defined planning areas, the department will update areas to reflect the revisions to the zip codes to be included in the certificate of need definitions, analyses and decisions. Post office boxes are not included.

(a) King County is divided by zip code into ((~~twelve~~)) 12 planning areas as follows:

KING ONE	KING TWO	KING THREE
98028 Kenmore	98101 Business District	98070 Vashon
98103 Green Lake	98102 Eastlake	98106 White Center/West Seattle
98105 Laurelhurst	98104 Business District	98116 Alki/West Seattle
98107 Ballard	98108 Georgetown	98126 West Seattle
98115 View Ridge/ Wedgwood	98109 Queen Anne	98136 West Seattle
98117 Crown Hill	98112 Madison/ Capitol Hill	98146 West Seattle
98125 Lake City	98118 Columbia City	98168 Riverton
98133 Northgate	98119 Queen Anne	
98155 Shoreline/ Lake Forest Park	98121 Denny Regrade	
98177 Richmond Beach	98122 Madrona	
98195 University of Washington	98134 Harbour Island	
	98144 Mt. Baker/ Rainier Valley	
	98199 Magnolia	

KING FOUR	KING FIVE	KING SIX
98148 SeaTac	98003 Federal Way	98011 Bothell
98158 SeaTac	98023 Federal Way	98033 Kirkland
98166 Burien/ Normandy Park		98034 Kirkland
98188 Tukwila/ SeaTac		98052 Redmond
98198 Des Moines		98053 Redmond
		98072 Woodinville
		98077 Woodinville

KING SEVEN	KING EIGHT	KING NINE
98004 Bellevue	98014 Carnation	98055 Renton
98005 Bellevue	98019 Duvall	98056 Renton
98006 Bellevue	98024 Fall City	98057 Renton
98007 Bellevue	98045 North Bend	98058 Renton
98008 Bellevue	98065 Snoqualmie	98059 Renton
98039 Medina	98027 Issaquah	98178 Skyway
98040 Mercer Island	98029 Issaquah	
	98074 Sammamish	
	98075 Sammamish	

KING TEN	KING ELEVEN	KING TWELVE
98030 Kent	98001 Auburn	98022 Enumclaw
98031 Kent	98002 Auburn	
98032 Kent	98010 Black Diamond	
98038 Maple Valley	98047 Pacific	
98042 Kent	98092 Auburn	
98051 Ravensdale		

(b) Pierce County is divided into five planning areas as follows:

PIERCE ONE	PIERCE TWO	PIERCE THREE
98354 Milton	98304 Ashford	98329 Gig Harbor
98371 Puyallup	98323 Carbonade	98332 Gig Harbor
98372 Puyallup	98328 Eatonville	98333 Fox Island
98373 Puyallup	98330 Elbe	98335 Gig Harbor
98374 Puyallup	98360 Orting	98349 Lakebay
98375 Puyallup	98338 Graham	98351 Longbranch
98390 Sumner	98321 Buckley	98394 Vaughn
98391 Bonney Lake		

PIERCE FOUR	PIERCE FIVE
98402 Tacoma	98303 Anderson Island
98403 Tacoma	98327 DuPont
98404 Tacoma	98387 Spanaway
98405 Tacoma	98388 Steilacoom
98406 Tacoma	98430 Tacoma
98407 Ruston	98433 Tacoma
98408 Tacoma	98438 Tacoma
98409 Lakewood	98439 Lakewood
98416 Tacoma	98444 Parkland
98418 Tacoma	98445 Parkland
98421 Tacoma	98446 Parkland
98422 Tacoma	98447 Tacoma
98424 Fife	98467 University Place
98443 Tacoma	98498 Lakewood
98465 Tacoma	98499 Lakewood
98466 Fircrest	98580 Roy

(c) Snohomish County is divided into three planning areas as follows:

SNOHOMISH ONE	SNOHOMISH TWO	SNOHOMISH THREE
98223 Arlington	98201 Everett	98012 Mill Creek/ Bothell
98241 Darrington	98203 Everett	98020 Edmonds/ Woodway
98252 Granite Falls	98204 Everett	98021 Bothell

SNOHOMISH ONE	SNOHOMISH TWO	SNOHOMISH THREE
98271 Tulalip Reservation/ Marysville	98205 Everett	98026 Edmonds
98282 Camano Island	98208 Everett	98036 Lynnwood/ Brier
98292 Stanwood	98251 Gold Bar	98037 Lynnwood
	98224 Baring	98043 Mountlake Terrace
	98258 Lake Stevens	98087 Lynnwood
	98270 Marysville	98296 Snohomish
	98272 Monroe	
	98275 Mukilteo	
	98288 Skykomish	
	98290 Snohomish	
	98294 Sultan	

(d) Spokane County is divided into two planning areas as follows:

SPOKANE ONE	SPOKANE TWO
99001 Airway Heights	99003 Chattaroy
99004 Cheney	99005 Colbert
99011 Fairchild Air Force Base	99006 Deer Park
99012 Fairfield	99009 Elk
99016 Greenacres	99021 Mead
99018 Latah	99025 Newman Lake
99019 Liberty Lake	99026 Nine Mile Falls
99022 Medical Lake	99027 Otis Orchards
99023 Mica	99205 Spokane
99030 Rockford	99207 Spokane
99031 Spangle	99208 Spokane
99036 Valleyford	99217 Spokane
99037 Veradale	99218 Spokane
99201 Spokane	99251 Spokane
99202 Spokane	
99203 Spokane	
99204 Spokane	
99206 Spokane Valley	
99212 Spokane Valley	
99216 Spokane/Spokane Valley	
99223 Spokane	
99224 Spokane	

((~~(16)~~)) (17) "Projection year" means the fifth calendar year after the base year. For example, reviews using 2015 end-of-year data as the base year will use 2020 as the projection year.

((~~(17)~~)) (18) "Quality incentive program" or "QIP" means the end-stage renal disease (ESRD) quality incentive program (QIP) administered by the Centers for Medicare and Medicaid Services (CMS). The QIP measures kidney ((~~dialysis facility~~)) disease treatment center performance based on outcomes assessed through specific performance and quality measures that are combined to create a total performance score (TPS). The QIP and TPS are updated annually and are publicly available on the CMS DFC website.

((~~(18)~~)) (19) "Quintile" means any of five groups into which a population can be divided according to the distribution of values of a particular variable.

((~~(19)~~)) (20) "Resident in-center patients" means in-center hemodialysis (HD) patients who reside within the planning area. If more than ((~~fifty~~)) 50 percent of a kidney ((~~dialysis facility's~~)) disease treatment center's patients reside outside Washington state, these out-of-state patients would be considered resident in-center patients.

((~~(20)~~)) (21) "Shelled space" means space that is constructed to meet future needs; it is a space enclosed by a building shell but otherwise unfinished inside unless the space designated for future needs is part of an existing, finished building prior to an applicant's proposed project. In that case, there is no requirement to degrade the space. The shelled space may include:

(a) Electrical and plumbing that will support future needs;

(b) Insulation;

(c) Sheet rock that is taped or other similar wall coverings that are otherwise unfinished; and

(d) Heating, ventilation, and air conditioning.

((~~(21)~~)) (22) "Temporary emergency situation" means a temporary emergency situation as defined in RCW 70.38.280 and WAC 246-310-825.

(23) "Training services" means services provided by a kidney ((~~dialysis facility~~)) disease treatment center to train patients for home dialysis. Home training spaces are not used to provide in-center dialysis treatments. Spaces used for training are not included in the ((~~facility's~~)) center's station count for projecting future station need or in calculating existing station use. Stations previously designated as "training stations" may be used as in-center dialysis stations and will continue to be included in the ((~~facility's~~)) center's current station count for projecting future station need or in calculating existing station use. For the purpose of awarding the point for home training in the superiority criteria section (WAC 246-310-823), training services include the following:

(a) Home peritoneal dialysis (HPD); and

(b) Home hemodialysis (HHD).

AMENDATORY SECTION (Amending WSR 17-04-062, filed 1/27/17, effective 1/1/18)

WAC 246-310-803 Kidney disease treatment ((~~facilities~~)) centers—Data reporting requirements. (1) By February 15th or the first working day thereafter of each year, each provider will electronically submit the following data elements for each of its kidney ((~~dialysis facilities~~)) disease treatment centers in the state of Washington and each out-of-state kidney ((~~dialysis facility~~)) disease treatment center that might be used in an application review during the next year (an out-of-state kidney ((~~dialysis facility~~)) disease treatment center may be used as one of the three closest ((~~facilities~~)) centers for a future project during the next year pursuant to WAC 246-310-827):

(a) Cost report data for the most recent calendar or fiscal year reporting period for which data is available reported to the Centers for Medicare and Medicaid Services (CMS) that is used to calculate net revenue per treatment; and

(b) Data reported to providers by CMS for the most recent calendar or fiscal year reporting period for which data is available to identify the percentage of nursing home patients and the average number of comorbid conditions.

(2) A provider's failure to submit complete data elements identified in subsection (1)(a) and (b) of this section in the format identified by the department for a ((~~facility~~)) center by the deadline in subsection (1) of this section or whose data for a ((~~facility~~)) center is not complete on the DFC report or QIP report (medicare website) will result in automatic rejection of concurrent review applications for that provider until the following year's data report deadline unless an exemption is granted pursuant to subsection (3) of this section. Corrections to the DFC report, as noted in WAC 246-310-827(7) do not require the filing on an exemption.

(3) A provider may request an exemption from subsection (2) of this section in writing by the first working day in March. The exemption request must demonstrate that reasonable efforts were made to timely submit the required data elements in subsection (1)(a) and (b) of this section. An exemption request based on missing data in the DFC report or QIP report should demonstrate the absence of data is not the result of failure to report to medicare. The department has sole discretion to grant these exemptions. The department will review all submitted exemption requests and respond with a decision by the first working day in April.

(4) Within ((~~ten~~)) 10 working days, providers must report to the department the date that kidney dialysis stations first became operational for the following:

(a) New kidney ((~~dialysis facility~~)) disease treatment center;

(b) Stations added to an existing kidney ((~~dialysis facility~~)) disease treatment center; or

(c) Relocated stations of a kidney ((~~dialysis facility~~)) disease treatment center.

(5) The department will confirm it has received the required data in subsections (1) and (4) of this section as well as any exemption requests in subsection (3) of this section via email within ((~~ten~~)) 10 working days of receipt.

(6) The department will publish on its website the date that the stations in subsection (4) of this section became operational.

AMENDATORY SECTION (Amending WSR 17-04-062, filed 1/27/17, effective 1/1/18)

WAC 246-310-806 Kidney disease treatment ((~~facilities~~)) centers ~~—~~Concurrent review cycles. The department will review kidney ((~~dialysis facility~~)) disease treatment center applications using the concurrent review cycles described in this section, unless the application was submitted as described in subsection (9) of this section. There are four concurrent review cycles each year.

(1) Applicants must submit applications for review according to the following table:

		Application Submission Period			Department Action	Application Review Period		
Concurrent Review Cycle	Letters of Intent Due	Receipt of Initial Application	End of Screening Period	Applicant Response	Beginning of Review	Public Comment Period (includes public hearing if requested)	Rebuttal Period	Exparte Period
Special Circumstances 1	First working day of **April** of each year.	First working day of **May** of each year.	**May 15** or the first working day thereafter.	**June 15** or the first working day thereafter.	**June 22** or the first working day thereafter.	**30-Day** Public comment period (including public hearing).	**7-Day** Rebuttal period.	**15-Day** Exparte period.
						Begins **June 23** or the first working day thereafter	Applicant and affected party response to public comment.	Department evaluation and decision.
Nonspecial Circumstance Cycle 1	First working day of **May** of each year.	First working day of **June** of each year.	Last working day of **June**.	Last working day of **July**.	**August 5** or the first working day thereafter.	**30-Day** Public comment period (including public hearing).	**30-Day** Rebuttal period.	**75-Day** Exparte period.
						Begins **August 6** or the first working day thereafter.	Applicant and affected party response to public comment.	Department evaluation and decision.
Special Circumstances 2	First working day of **October** of each year.	First working day of **November** of each year.	**November 15** or the first working day thereafter.	**December 15** or the first working day thereafter.	**December 22** or the first working day thereafter.	**30-Day** Public comment period (including public hearing).	**7-Day** Rebuttal period.	**15-Day** Exparte period.
						Begins **December 23** or the first working day thereafter.	Applicant and affected party response to public comment.	Department evaluation and decision.
Nonspecial Circumstances Cycle 2	First working day of **November** of each year.	First working day of **December** of each year.	Last working day of **December**.	Last working day of **January**.	**February 5** or the first working day thereafter.	**30-Day** Public comment period (including public hearing).	**30-Day** Rebuttal period.	**75-Day** Exparte period.
						Begins **February 6** or the first working day thereafter.	Applicant and affected party response to public comment.	Department evaluation and decision.

(2) The department should complete a nonspecial circumstance concurrent review cycle within nine months, which begins the first day after letters of intent are due for that particular review cycle. The department should complete the regular review process within six months, which begins the first day after the letters of intent are due for that particular review cycle.

(3) The department will notify applicants ((~~fifteen~~)) 15 days prior to the scheduled decision date if it is unable to meet the decision deadline on the applications. In that event, the department will establish and commit to a new decision date.

(4) When two or more applications are submitted for the same planning area, the department will first evaluate each application in-

dependently for meeting the applicable standards described in WAC 246-310-210, 246-310-220, 246-310-230, and 246-310-240. If two or more applications independently meet those four standards, the department will apply the superiority criteria in WAC 246-310-827 to determine the superior application under WAC 246-310-240(1).

(5) An applicant receiving points for the purposes of the superiority criteria under WAC 246-310-827 (3)(e), (f), or (g) may only apply for station need in one planning area per review cycle.

(6) An applicant receiving points for purposes of the superiority criteria under WAC 246-310-827 (3)(e), (f), or (g) must operate the newly awarded stations for a period of time long enough to have a full year of data reporting medicare cost report worksheets and a full year of data reporting the ((~~dialysis facility~~)) kidney disease treatment center report prior to any future applications.

(7) The department will not accept new nonspecial circumstance applications for a planning area if there are any nonspecial circumstance applications for which the certificate of need program has not made a decision in that planning area filed under a previous concurrent review cycle. This restriction does not apply if the department has not made a decision on the pending applications within the review timelines of nine months for a concurrent review and six months for a regular review. This restriction also does not apply to special circumstance applications.

(8) The department may convert the review of a nonspecial circumstance application that was initially submitted under a concurrent review cycle to a regular review process if the department determines that the nonspecial circumstance application does not compete with another nonspecial circumstance application.

(9) Pending certificate of need applications. Kidney ((~~dialysis facility~~)) disease treatment center applications submitted prior to the effective date of these rules will be reviewed and action taken based on the rules that were in effect on the date the applications were received.

AMENDATORY SECTION (Amending WSR 17-04-062, filed 1/27/17, effective 1/1/18)

WAC 246-310-812 Kidney disease treatment ((~~facilities~~)) centers —Methodology. A kidney ((~~dialysis facility~~)) disease treatment center that provides hemodialysis or peritoneal dialysis, training, or backup must meet the following standards in addition to applicable review criteria in WAC 246-310-210, 246-310-220, 246-310-230, and 246-310-240.

(1) Applications for new stations may only address projected station need in the planning area in which the ((~~facility~~)) center is to be located.

(a) If there is no existing ((~~facility~~)) center in an adjacent planning area, the application may also address the projected station need in that planning area.

(b) Station need projections must be calculated separately for each planning area within the application.

(2) Data used to project station need must be the most recent five-year resident end-of-year in-center patient data available from

the ((~~Northwest Renal~~)) Network as of the letter of intent submission date, concluding with the base year at the time of application.

(3) Projected station need must be based on 4.8 resident in-center patients per station (4.8 planning area) for all planning areas except Adams, Columbia, Douglas, Ferry, Garfield, Jefferson, Kittitas, Klickitat, Lincoln, Okanogan, Pacific, Pend Oreille, San Juan, Skamania, Stevens, Wahkiakum, and Whitman counties. The projected station need for these exception planning areas must be based on 3.2 resident in-center patients per station (3.2 planning area).

(4) The number of dialysis stations projected as needed in a planning area will be determined by using the following methodology:

(a) Determine the type of regression analysis to be used to project resident in-center station need by calculating the annual growth rate in the planning area using the end-of-year number of resident in-center patients for each of the previous six consecutive years, concluding with the base year.

(i) If the planning area has experienced less than six percent growth in any of the previous five annual changes calculations, use linear regression to project station need; or

(ii) If the planning area has experienced six percent or greater growth in each of the previous five annual changes, use nonlinear (exponential) regression to project station need.

(b) Project the number of resident in-center patients in the projection year using the regression type determined in (a) of this subsection. When performing the regression analysis use the previous five consecutive years of end-of-year data concluding with the base year. For example, if the base year is 2015, use end-of-year data for 2011 through 2015 to perform the regression analysis.

(c) Determine the number of dialysis stations needed to serve resident in-center patients in the planning area in the projection year by dividing the result of (b) of this subsection by the appropriate resident in-center patient per station number from subsection (3) of this section. In order to assure access, fractional numbers are rounded up to the nearest whole number. For example, 5.1 would be rounded to 6.0. Rounding to a whole number is only allowed for determining the number of stations needed.

(d) To determine the net station need for a planning area, subtract the number calculated in (c) of this subsection from the total number of certificate of need approved stations located in the planning area. This number does not include the one department recognized exempt isolation station defined in WAC 246-310-800(9)<u>, nor does it include any dialysis stations added during a temporary emergency situation</u>. For example, a kidney ((~~dialysis facility~~)) <u>disease treatment center</u> that is certificate of need approved and certified for ((~~eleven~~)) <u>11</u> stations would subtract the one exempt isolation station and use ((~~ten~~)) <u>10</u> stations for the methodology calculations.

(5) Before the department approves new in-center kidney dialysis stations in a 4.8 planning area, all certificate of need counted stations at each ((~~facility~~)) <u>center</u> in the planning area must be operating at 4.5 in-center patients per station. However, when a planning area has one or more ((~~facilities~~)) <u>centers</u> with stations not meeting the in-center patients per stations standard, the department will consider the 4.5 in-center patients per station standard met for those ((~~facilities~~)) <u>centers</u> when:

(a) All stations for a ((~~facility~~)) <u>center</u> have been in operation for at least three years<u>, excluding temporary emergency situation stations</u>; or

(b) Certificate of need approved stations for a ((~~facility~~)) center have not become operational within the timeline as represented in the approved application. For example, an applicant states the stations will be operational within eight months following the date of the certificate of need approval. The eight months would start from the date of an uncontested certificate of need approval. If the certificate of need approval is contested, the eight months would start from the date of the final department or judicial order. However, the department, at its sole discretion, may approve a one-time modification of the timeline for purposes of this subsection upon submission of documentation that the applicant was prevented from meeting the initial timeline due to circumstances beyond its control.

Both resident and nonresident patients using the kidney ((~~dialysis facility~~)) disease treatment center are included in this calculation. Data used to make this calculation must be from the most recent quarterly modality report from the ((~~Northwest Renal~~)) Network as of the letter of intent submission date; or

(c) If a center was affected by a temporary emergency situation at the time of the patient census estimates presented in the most recent quarterly modality report from the Network as of the letter of intent submission date, then the in-center census data for the affected center must come from the quarterly modality report from the Network that directly precedes the date that the temporary emergency situation exemption request was submitted to the department for the affected center.

(6) Before the department approves new in-center kidney dialysis stations in a 3.2 planning area, all certificate of need counted stations at each ((~~facility~~)) center in the planning area must be operating at or above 3.2 in-center patients per station. If the certificate of need approval is contested, the eight months would start from the date of the final department or judicial order. However, when a planning area has ((~~facilities~~)) centers with stations not meeting the in-center patients per station standard, the department will consider the 3.2 in-center patients per station standard met for those ((~~facilities~~)) centers when:

(a) All stations for a ((~~facility~~)) center have been in operation for at least three years, excluding temporary emergency situation stations; or

(b) Certificate of need approved stations for a ((~~facility~~)) center have not become operational within the timeline as represented in the approved application. For example, an applicant states the stations will be operational within eight months following the date of the certificate of need approval. The eight months would start from the date of an uncontested certificate of need approval. However, the department, at its sole discretion, may approve a one-time modification of the timeline for the purposes of this subsection upon submission of documentation that the applicant was prevented from meeting the initial timeline due to circumstances beyond its control.

Both resident and nonresident patients using the kidney ((~~dialysis facility~~)) disease treatment center are included in this calculation. Data used to make this calculation must be from the most recent quarterly modality report from the ((~~Northwest Renal~~)) Network as of the letter of intent submission date; or

(c) If a center was affected by a temporary emergency situation at the time of the patient census estimates presented in the most recent quarterly modality report from the Network as of the letter of intent submission date, then the in-center census data for the affec-

ted center must come from the quarterly modality report from the Network that directly precedes the date that the temporary emergency situation exemption request was submitted to the department for the affected center.

(7) If a kidney disease treatment center was affected by a temporary emergency situation other than a staffing shortage, the department will continue to include the affected center's total number of certificate of need approved permanent stations in the supply for the planning area, unless, in the department's discretion, including the affected center's stations in the supply would negatively impact access to dialysis services.

(8) When there are relocated stations within a planning area pursuant to WAC 246-310-830(3) and data is not available for the relocated stations, the department will use the station use rate from the previous location as reported on the last quarterly modality report from ((~~Northwest Renal~~)) the Network.

((~~(8)~~)) (9) If a provider, including any affiliates, submits multiple applications for projected need in a planning area, the department will use the following process:

(a) Each application will be scored as an individual application to determine superiority.

(b) The sum of the stations requested in the applications cannot exceed the projected need at the time of applications in the planning area.

AMENDATORY SECTION (Amending WSR 17-04-062, filed 1/27/17, effective 1/1/18)

WAC 246-310-815 Kidney disease treatment ((~~facilities~~)) centers—Financial feasibility. (1) The kidney ((~~dialysis facility~~)) disease treatment center must demonstrate positive net income by the third full year of operation.

(a) The calculation of net income is a subtraction of all operating and nonoperating expenses, including appropriate allocated and overhead expenses, amortization and depreciation of capital expenditures from total revenue generated by the kidney ((~~dialysis facility~~)) disease treatment center.

(b) Existing facilities. Revenue and expense projections for existing ((~~facilities~~)) kidney disease treatment centers must be based on that ((~~facility's~~)) center's current payor mix and current expenses.

(c) New facilities.

(i) Revenue projections must be based on the net revenue per treatment of the applicant's three closest ((~~dialysis facilities~~)) kidney disease treatment centers.

(ii) Known expenses must be used in the pro forma income statement. Known expenses may include, but are not limited to, rent, medical director agreement, and other types of contracted services.

(iii) All other expenses not known must be based on the applicant's three closest ((~~dialysis facilities~~)) kidney disease treatment centers.

(iv) If an applicant has no experience operating kidney ((~~dialysis facilities~~)) disease treatment centers, the department will use

its experience in determining the reasonableness of the pro forma financial statements provided in the application.

(v) If an applicant has one or two kidney ((~~dialysis facilities~~)) disease treatment centers, revenue projections and unknown expenses must be based on the applicant's operational ((~~facilities~~)) centers.

(2) An applicant proposing to construct finished treatment floor area square footage that exceeds the maximum treatment floor area square footage defined in WAC 246-310-800(11) will be determined to have an unreasonable impact on costs and charges and the application will be denied. This does not preclude an applicant from constructing shelled space.

AMENDATORY SECTION (Amending WSR 17-04-062, filed 1/27/17, effective 1/1/18)

WAC 246-310-818 Special circumstances one- or two-station expansion—Eligibility criteria and application process. (1) The department will approve one or two additional special circumstance stations for an existing kidney ((~~dialysis facility (facility)~~)) disease treatment center (center) if it meets the following criteria, regardless of whether the need methodology in WAC 246-310-812 projects a need for additional stations in the planning area:

(a) For 4.8 planning areas, the ((~~facility~~)) center has operated at or above an average of 5.0 patients per station for the most recent six consecutive month period preceding the letter of intent submission date for which data is available. Data used to determine patients per station must be obtained from the ((~~Northwest Renal~~)) Network; or

(b) For 3.2 planning areas, the ((~~facility~~)) center has operated at or above an average of 3.5 patients per station for the most recent six consecutive month period preceding the letter of intent submission date for which data is available. Data used to determine patients per station must be obtained from the ((~~Northwest Renal~~)) Network; and

(c) The ((~~facility~~)) center can accommodate one or two additional stations within its existing building, which may include shelled space. If renovation is needed to accommodate the additional station(s), renovation must be within the existing building.

(2) The department may approve special circumstance station expansions even if other kidney ((~~dialysis facilities~~)) disease treatment centers not owned or affiliated with the applicant in the planning area are below the minimum patients per station operating thresholds set by WAC 246-310-812 (5) or (6).

(3) A ((~~facility~~)) center approved for two special circumstance stations under subsection (1) of this section is not eligible for further special circumstance expansions under this subsection until the department awards additional nonspecial circumstances kidney ((~~dialysis stations~~)) disease treatment centers in the planning area.

(4) As of the effective date of these rules, a ((~~facility~~)) center that has relocated all or part of its stations may not request a special circumstance one- or two-station expansion until three years have lapsed from the date the stations become operational. The three-year prohibition applies to any new kidney ((~~dialysis facility~~)) disease treatment center or ((~~facilities~~)) centers whose station count is changed by the relocation of stations. The three-year prohibition will be retrospectively applied only to kidney ((~~dialysis facilities~~)) dis-

ease treatment centers that were approved for partial or complete relocation after January 1, 2015.

(5) For 4.8 planning areas, a ((~~facility~~)) center is ineligible for a special circumstance one- or two-station expansion if the owner or affiliate has approved certificate of need stations in the planning area that have operated below an average of 4.5 patients per station for the most recent six consecutive month period preceding the letter of intent submission date. Data used to calculate patients per station must be obtained from the ((~~Northwest Renal~~)) Network.

(6) For 3.2 planning areas, a ((~~facility~~)) center is ineligible for a special circumstance one- or two-station expansion if the owner or affiliate has approved certificate of need stations in the planning area that have operated below an average of 3.2 patients per station for the most recent six consecutive month period preceding the letter of intent submission date. Data used to calculate patients per station must be obtained from the ((~~Northwest Renal~~)) Network.

(7) For 4.8 planning areas, a special circumstance one- or two-station expansion will not be approved if, with the requested new station(s), the applicant's kidney ((~~dialysis facility~~)) disease treatment center would fall below a calculated 4.5 patients per station. Data used to make this calculation is the average patients per station from subsection (1)(a) of this section.

(8) For 3.2 planning areas, a special circumstance one- or two-station expansion will not be approved if, with the requested new stations(s), the applicant's kidney ((~~dialysis facility~~)) disease treatment center would fall below a calculated 3.0 patient per station. Data used to make this calculation is the average patients per station from subsection (1)(b) of this section.

(9) If a provider operates one or more kidney ((~~dialysis facilities~~)) disease treatment centers within a planning area and applies for a special circumstance one- or two-station expansion in the planning area the department will not accept a letter of intent from that provider for additional stations to meet projected planning area need in the next nonspecial circumstance concurrent review cycle.

(10) Station(s) approved under this section must be operational within six months of approval, otherwise the approval is revoked.

(11) The department will provide a special circumstance one- or two-station expansion application form that incorporates the criteria for certificate of need approval. The application will not be approved unless the criteria are met. Special circumstances applications are evaluated independently of one another and accordingly without reference to the superiority criteria set forth in WAC 246-310-827. Therefore, multiple special circumstances applications may be approved in the same planning area during the same concurrent review cycle.

(12) Applicants must submit special circumstance one- or two-station expansion applications according to the schedule set forth in WAC 246-310-806(1).

(13) Special circumstance station applications will be treated as approved and will reduce net station need in the planning area when no nonspecial circumstance applications decisions are pending within the planning area. Special circumstance application approvals will not result in a reduction of net station need in the planning area when nonspecial circumstance application approvals decisions are pending within the planning area.

(14) The department will review special circumstance requests with the following considerations related to temporary emergency stations defined in WAC 246-310-825 and RCW 70.38.280.

(a) All calculations described in this section exclude temporary emergency stations.

(b) A center that operated temporary emergency stations due to a staffing shortage emergency situation, during the most recent six consecutive month period preceding the letter of intent submission date, is eligible to apply for special circumstances, if it has met all eligibility criteria described in this section. Centers operating temporary emergency stations during this period for temporary emergency situations other than staffing shortages are ineligible for special circumstance expansions.

(c) Pursuant to RCW 70.38.280 (2)(d), a center that operated temporary emergency stations due to a staffing shortage emergency situation may not exceed the number of patients served at the time of the exemption request. All calculations described in this section for the review of a center that operated temporary emergency stations due to staffing shortage emergency will have its patient census reported in the Network data limited to a maximum of the patients served at the time of the emergency request for the months when the temporary emergency was in effect.

AMENDATORY SECTION (Amending WSR 17-04-062, filed 1/27/17, effective 1/1/18)

WAC 246-310-821 Kidney disease treatment ((~~facilities~~)) centers—Standards for planning areas without an existing ((~~facility~~)) center. (1) Columbia, Ferry, Garfield, Klickitat, Lincoln, Pend Oreille, San Juan, Skamania, Stevens, Wahkiakum, and Whitman counties do not have an existing kidney ((~~dialysis facility~~)) disease treatment center as of the effective date of these rules. The department will award the first project proposing to establish a ((~~facility~~)) center in each of these planning areas as follows:

(a) A minimum of four stations, provided the project meets applicable review criteria and standards; and

(b) The ((~~facility~~)) center must be projected to operate at 3.2 in-center patients per station by the third full year of operation. For purposes of this subsection, the applicant may supplement data obtained from the ((~~Northwest Renal~~)) Network with other documented demographic and utilization data to demonstrate station need.

(2) Once a county no longer qualifies under subsection (1) of this section, the county remains a 3.2 in-center patient per station county. As of the effective date of these rules, Adams, Douglas, Jefferson, Kittitas, Okanogan, Pacific, and Stevens counties are also identified as 3.2 in-center patient per station counties.

AMENDATORY SECTION (Amending WSR 17-04-062, filed 1/27/17, effective 1/1/18)

WAC 246-310-824 Kidney disease treatment centers—Exceptions. The department will not approve new stations in a planning area if the projections in WAC 246-310-812(4) show no net need, and will not approve more than the number of stations projected as needed unless:

(1) The proposed project qualifies under WAC 246-310-818 for special circumstances one- or two-station expansions; or

(2) All other applicable review criteria and standards have been met; and

(3) One or more of the following have been met:

(a) The department finds the additional stations are needed to be located reasonably close to the people they serve; or

(b) Existing dialysis stations in the kidney ((~~dialysis facility~~)) disease treatment center requesting the exception are operating at 5.5 patients for a 4.8 planning area or, 3.7 patients per station for the 3.2 planning areas. Data used to make this calculation must be from the most recent quarterly modality report from the ((~~Northwest Renal~~)) Network as of the letter of intent submission date; or

(c) The applicant documents a significant change in ESRD treatment practice has occurred, affecting dialysis station use in the planning area; and

(4) The department finds that exceptional circumstances exist within the planning area and explains the approval of additional stations in writing.

NEW SECTION

WAC 246-310-825 Kidney disease treatment centers—Temporary emergency situation exemption. The department may grant a kidney disease treatment center an exemption to exceed its authorized number of dialysis stations during a temporary emergency situation.

(1) In addition to the temporary emergency situations identified in RCW 70.38.280(2), the following are defined as temporary emergency situations:

(a) Any state or federal emergency declaration issued by a state or federal entity that has a direct impact on availability, operations, or patient access to kidney dialysis services in Washington state; and

(b) Any other temporary emergency situations that in the department's discretion constitute a "temporary emergency situation."

(2) For purposes of RCW 70.38.280 (2)(d), the following definitions apply:

(a) "Staffing shortage" means that kidney disease treatment center does not have sufficient staff to safely provide treatment.

(b) "Reconfiguration" means the addition of dialysis stations to facilitate the delivery of dialysis services, provided the center does not exceed the number of patients served at the time of the exemption request.

(3) In order to be granted a temporary emergency situation exemption, a kidney disease treatment center must make a written request to the department consistent with RCW 70.38.280(3). In addition to the information required in RCW 70.38.280(3), the following information is required:

(a) A specific description of the actions the kidney disease treatment center will take to address the temporary emergency situation;

(b) For temporary emergency situations other than those caused by staffing shortages, identify each center expected to be affected by the temporary emergency situation. Kidney disease treatment centers

expected to be affected by the temporary emergency situation includes the center requesting temporary emergency stations and any center that suspends operations due to circumstances that qualify as a temporary emergency situation;

(c) The number of stations the center intends to add during the duration of the temporary emergency situation;

(d) The number of shifts the center proposes to operate during the duration of the temporary emergency situation; and

(e) Whether a capital expenditure will be made to remedy the temporary emergency situation.

(4) A kidney disease treatment center may submit a temporary emergency situation exemption request at any time and is not subject to the concurrent review cycles for kidney disease treatment centers in WAC 246-310-806.

(5) A kidney disease treatment center's certificate of need shall remain in full effect even if the center is required to suspend operations, in part or in its entirety, only if partial or full facility closure is due to circumstances that qualify under WAC 246-310-825(1) and the department approves a temporary emergency situation exemption request. The center may restore its full approved stations once the temporary emergency has ended without having to reapply for certificate of need approval.

AMENDATORY SECTION (Amending WSR 17-04-062, filed 1/27/17, effective 1/1/18)

WAC 246-310-827 Kidney disease treatment ((~~facilities~~)) centers ——Superiority criteria. For purposes of determining which of the competing applications should be approved, the criteria in this section will be used as the only means for comparing two or more applications to each other. No other criteria or measures will be used in comparing two or more applications to each other under any of the applicable subcriteria within WAC 246-310-210, 246-310-220, 246-310-230 or 246-310-240.

(1) An application will be denied if it fails to meet any criteria under WAC 246-310-210, 246-310-220, 246-310-230, or 246-310-240 (2) or (3).

(2) An application will be denied if the applicant has one or more kidney ((~~dialysis facilities~~)) disease treatment centers in the planning area not meeting the 4.5 or 3.2 in-center patients per station standards required in WAC 246-310-812 (5) or (6) as of the most recent quarterly report from the ((~~Northwest Renal~~)) Network as of the date of the letter of intent.

(3) When available, Washington ((~~facilities~~)) kidney disease treatment centers must be used as comparables, as follows:

(a) For existing kidney ((~~dialysis facilities~~)) disease treatment centers proposing to expand, use data for the existing ((~~facility~~)) center plus the next two closest Washington ((~~facilities~~)) centers as comparables owned by or affiliated with the applicant as measured by a straight line. Straight lines will be calculated using "Google Maps" or equivalent mapping software (mileage calculated out to two decimal points, no rounding).

(b) For new kidney ((~~dialysis facilities~~)) disease treatment centers, use data for the next three closest ((~~facilities~~)) centers as

comparables owned by or affiliated with the applicant as measured by a straight line from the proposed new kidney ((~~dialysis facility~~)) disease treatment center location. Straight lines will be calculated using "Google Maps" or equivalent mapping software (mileage calculated out to two decimal points, no rounding).

(c) The number of applications per concurrent review cycle that rely on the same three comparables is limited to two.

(d) If complete medicare data is not available for any of the kidney ((~~dialysis facilities~~)) disease treatment centers and a ((~~facility~~)) center has been granted a department exemption in WAC 246-310-803(3), then that ((~~facility~~)) center will not be used as a comparable and the next closest ((~~facility~~)) center should be used as a comparable.

(e) If the applicant currently does not own or is not affiliated with any kidney ((~~dialysis facility~~)) disease treatment center, the department will assign the following points:

(i) The median quintile points for those superiority measures using quintiles (excluding net revenue per treatment);

(ii) Two points for standardized mortality ratio (SMR);

(iii) Two points for standardized hospitalization ratio (SHR); and

(iv) Any remaining points for other measures will be based on the representations made in the application.

(f) If the applicant owns or is affiliated with one existing kidney ((~~dialysis facility~~)) disease treatment center in total, the department will assign the ((~~facility's~~)) center's actual points as follows:

(i) The actual quintile points for those superiority measures using quintiles;

(ii) The actual points for SMR;

(iii) The actual points for SHR; and

(iv) Any remaining points for other measures will be based on the representations made in the application.

(g) If the applicant owns or is affiliated with two existing kidney ((~~dialysis facilities in total~~)) disease treatment centers, the department will average the ((~~facility's~~)) center's scores as follows:

(i) The average quintile points for those superiority measures using quintiles;

(ii) The average points for SMR;

(iii) The average points for SHR; and

(iv) The average of the remaining points for other measures will be based on the representations made in the applications.

(4) The following table identifies the data measures and the data sources:

Data Item	Source
Home peritoneal dialysis and home hemodialysis training (Yes or No)	DFC report
Shift beginning after 5:00 p.m.? (Yes or No)	DFC report
Nursing home residents percentage (quintile)	Dialysis facility report (DFR)
Average number of comorbidities claimed (quintile)	Dialysis facility report (DFR)

Data Item	Source
Standardized mortality ratio performance (SMR) (better than expected, as expected, worse than expected)	DFC report - 4 year
Standardized hospitalization ratio performance (SHR) (better than expected, as expected, worse than expected)	DFC report - 1 year
Medicare total performance score (quintile)	QIP report
Net revenue per treatment (quintile)	Department calculation from medicare cost report. Divide total revenue by total treatments.

(5) The department will obtain the medicare QIP total performance scores (QIP Report) and the kidney dialysis facility compare reports (DFC Report) from the medicare website on the first working day in February.

(6) The department will determine the quintile scores and non-quintile scores. The department will calculate the quintile scores using the following process for each quintile measure:

(a) For all kidney ((~~dialysis facilities~~)) disease treatment centers for which data is available, sort the ((~~facilities~~)) centers from most favorable to least favorable according to the identified data.

(b) Use the percent rank formula using Excel to create the percentile ranking for each kidney ((~~dialysis facility~~)) disease treatment center in the data set. The array used in the formula is the data set of available ((~~facility~~)) center data identified for that measure.

(c) Assign quintile and nonquintile scores using the following methods:

(i) Quintile measures. For nursing home resident percentage, number of comorbidities, and QIP total performance score measures, the department will determine the quintile scores using the following process:

(A) ((~~Dialysis facilities~~)) Kidney disease treatment centers with a percentile ranking of ((~~eighty~~)) 80 percent or higher get five points.

(B) ((~~Dialysis facilities~~)) Kidney disease treatment centers with a percentile ranking less than ((~~eighty~~)) 80 percent and greater than or equal to ((~~sixty~~)) 60 percent get four points.

(C) ((~~Dialysis facilities~~)) Kidney disease treatment centers with a percentile ranking less than ((~~sixty~~)) 60 percent and greater than or equal to ((~~forty~~)) 40 percent get three points.

(D) ((~~Dialysis facilities~~)) Kidney disease treatment centers with a percentile ranking less than ((~~forty~~)) 40 percent and greater than or equal to ((~~twenty~~)) 20 percent get two points.

(E) ((~~Dialysis facilities~~)) Kidney disease treatment centers with a percentile ranking below ((~~twenty~~)) 20 percent get one point.

(ii) Quintile measure. For the net revenue per treatment measure, the department will determine the quintile scores using the following process:

(A) ((~~Dialysis facilities~~)) Kidney disease treatment centers with a percentile ranking of ((~~eighty~~)) 80 percent or higher get one point.

(B) ((~~Dialysis facilities~~)) Kidney disease treatment centers with a percentile ranking less than ((~~eighty~~)) 80 percent and greater than or equal to ((~~sixty~~)) 60 percent get two points.

(C) ((~~Dialysis facilities~~)) Kidney disease treatment centers with a percentile ranking less than ((~~sixty~~)) 60 percent and greater than or equal to ((~~forty~~)) 40 percent get three points.

(D) ((~~Dialysis facilities~~)) Kidney disease treatment centers with a percentile ranking less than ((~~forty~~)) 40 percent and greater than or equal to ((~~twenty~~)) 20 percent get four points.

(E) ((~~Dialysis facilities~~)) Kidney disease treatment centers with a percentile ranking below ((~~twenty~~)) 20 percent get five points.

(F) Hospitals that do not have a cost report may submit net revenue per treatment actuals from the previous year. Hospitals must also submit a signed attestation stating the net revenue per treatment data is accurate.

(iii) Nonquintile measures. The department will determine the nonquintile scores using the following process:

(A) ((~~Dialysis facilities~~)) Kidney disease treatment centers that offer training services are given one point.

(B) ((~~Dialysis facilities~~)) Kidney disease treatment centers that offer a shift that begins after 5 p.m. are given one point.

(C) The department will determine SMR points for ((~~dialysis facilities~~)) kidney disease treatment centers as follows:

(I) "Better than expected" get four points.

(II) "As expected" get two points.

(III) "Worse than expected" get 0 points.

(D) The department will determine SHR points for ((~~dialysis facilities~~)) kidney disease treatment centers as follows:

(I) "Better than expected" get four points.

(II) "As expected" get two points.

(III) "Worse than expected" get 0 points.

(E) The department will assign two points for an "as expected" score for ((~~dialysis facilities~~)) kidney disease treatment centers missing only SMR data from the DFC report, provided the ((~~facility~~)) center was granted an exception under WAC 246-310-803(3).

(7) The department will publish the data set including resulting scores and quintiles for all kidney ((~~dialysis facilities~~)) disease treatment centers for review no later than March 15th or the first working day thereafter. The data set, including resulting scores and quintiles, will remain open for review and any person may propose the correction of data to the department for seven calendar days. Correction of data may be proposed as follows:

(a) Training services (HPD and HHD): The department will accept a copy of a medicare certification for training services (HPD and HHD) as evidence that a kidney ((~~dialysis facility~~)) disease treatment center provides these services, regardless of what is represented in the DFC report.

(b) Data related to a shift beginning after 5 p.m.: The department will accept an attestation that a ((~~facility~~)) center either operates a shift beginning after 5 p.m. or will operate that shift if there is a need, regardless of what is represented in the DFC report.

(c) The department will publish the final data set, including resulting scores and quintiles, no later than the first working day in April.

(8) The department will do the following analysis in order to determine the superior application:

(a) Create the comparable kidney ((~~dialysis facility~~)) disease treatment center set for each application per subsection (3) of this section.

(b) Determine the individual measure scores for each application by taking the simple average of the comparable scores for each measure.

(c) Determine the total score in the following manner according to the table below:

Data Items:	Calculation of Points	Score
Home training	The average score of comparable ((~~facilities~~)) centers rounded up to two decimal places.	
Shift beginning after 5 p.m.	The average score of comparable ((~~facilities~~)) centers rounded up to two decimal places.	
Nursing home residents	Average quintile score of comparable ((~~facilities~~)) centers rounded up to two decimal places.	
Average number of comorbid conditions	Average quintile score of comparable ((~~facilities~~)) centers multiplied by 1.25 and rounded up to two decimal places.	
Standardized mortality ratio	Average score of comparable ((~~facilities~~)) centers rounded up to two decimal places.	
Standardized hospitalization ratio	Average score of comparable ((~~facilities~~)) centers rounded up to two decimal places.	
QIP total performance score	Average quintile score of comparable ((~~facilities~~)) centers multiplied by 2.0 and rounded up to two decimal places.	
Net revenue per treatment	Average quintile score of comparable ((~~facilities~~)) centers rounded down to two decimal places.	
Total score	Sum each of these individual average scores to arrive at total score.	

(9) The application with the highest total score will be the superior alternative for the purpose of meeting WAC 246-310-240(1).

(10) After applying the superiority criterion in this section, if applications are tied, the department will use the following process to determine the superior alternative:

(a) An applicant that was assigned points under subsection (3)(e) of this section in the superiority analysis will be considered the superior alternative; if no applicant was assigned points under subsection (3)(e) of this section, apply (b) of this subsection:

(b) The applicant with the highest average QIP total performance score will be considered the superior alternative;

(c) If applications have the same average QIP total performance score, the applicant with the lowest average net revenue per treatment will be considered the superior alternative.

AMENDATORY SECTION (Amending WSR 17-04-062, filed 1/27/17, effective 1/1/18)

WAC 246-310-830 Kidney disease treatment ((~~facilities~~)) centers—Relocation of ((~~facilities~~)) centers. (1) When an existing ((~~facility~~)) kidney disease treatment center proposes to relocate any of its stations to another planning area, a new health care facility is considered to be established under WAC 246-310-020 (1)(a).

(2) When an existing kidney ((~~dialysis facility~~)) disease treatment center proposes to relocate a portion but not all of its stations within the same planning area, a new health care facility is considered to be established under WAC 246-310-020 (1)(a).

(3) When an existing kidney ((~~dialysis facility~~)) disease treatment center proposes to relocate a portion but not all of its stations to an existing ((~~facility~~)) center, it will be considered a station addition under WAC 246-310-020 (1)(e).

(4) When an entire existing kidney ((~~dialysis facility~~)) disease treatment center proposes to relocate all of its stations within the same planning area, a new health care facility is not considered to be established under WAC 246-310-020 (1)(a) if:

(a) The existing kidney ((~~dialysis facility~~)) disease treatment center ceases operation after the relocation;

(b) No new stations are added to the replacement kidney ((~~dialysis facility~~)) disease treatment center. The maximum treatment floor area square footage as defined in WAC 246-310-800 (11)(a) is limited to the number of certificate of need stations that were approved at the existing ((~~facility~~)) center;

(c) There is no break in service between the closure of the existing kidney ((~~dialysis facility~~)) disease treatment center and the operation of the replacement ((~~facility~~)) center;

(d) The existing ((~~facility~~)) center has been in operation for at least five years at its present location; and

(e) The existing kidney ((~~dialysis facility~~)) disease treatment center has not been purchased, sold, or leased within the past five years.

(5) Station use rates at new ((~~facilities~~)) kidney disease treatment centers created by the total relocation of an existing ((~~facility~~)) center or the partial relocation of an existing ((~~facility~~)) center should not be a barrier to the addition of new stations projected as needed for the planning area. In 4.8 planning areas, the station use rate will be counted as 4.5 in-center patients per station. If the

department has had to count the station use at 4.5 under the need methodology described in WAC 246-310-812(5), the ((~~facility~~)) center may not request additional stations at the new ((~~facility~~)) center for three years from the date the stations become operational or the ((~~facility~~)) center meets the 4.5 station use standard, whichever comes first. Data used to make this determination will be the most recent ((~~Northwest Renal~~)) Network quarterly modality report available as of the letter of intent submission date.

(6) Station use rates at new ((~~facilities~~)) kidney disease treatment centers created by the total relocation of an existing ((~~facility~~)) center or the partial relocation of an existing ((~~facility~~)) center should not be a barrier to the addition of new stations projected as needed for the planning area. In 3.2 planning areas, the station use rate will be counted as 3.2 in-center patients per station. If the department has had to count the station use at 3.2 under the need methodology described in WAC 246-310-812(6), the ((~~facility~~)) center may not request additional stations at the new ((~~facility~~)) center for three years from the date the stations become operational or the ((~~facility~~)) center meets the 3.2 station use standard, whichever comes first. Data used to make this determination will be the most recent ((~~Northwest Renal~~)) Network quarterly modality report available as of the letter of intent submission date.

AMENDATORY SECTION (Amending WSR 17-04-062, filed 1/27/17, effective 1/1/18)

WAC 246-310-833 One-time state border kidney ((~~dialysis facility~~)) disease treatment center station relocation. (1) When an existing owner-operator of a Washington state kidney ((~~dialysis facility~~)) disease treatment center is also the owner-operator of a kidney ((~~dialysis facility~~)) disease treatment center in a contiguous Idaho or Oregon county, the department will not consider a ((~~facility~~)) center that combines the Washington ((~~facility~~)) center and the out-of-state ((~~facility~~)) center to be a new health care ((~~facility~~)) center under WAC 246-310-020(1) provided all of the following criteria are satisfied:

(a) The Washington state kidney ((~~dialysis facility~~)) disease treatment center is located in Asotin, Benton, Clark, Columbia, Cowlitz, Garfield, Klickitat, Pend Oreille, Skamania, Wahkiakum, Walla Walla, or Whitman counties;

(b) The kidney ((~~dialysis facility~~)) disease treatment center is the sole provider of dialysis services in the Washington state county;

(c) The kidney ((~~dialysis facility~~)) disease treatment center is the sole provider of dialysis services in the contiguous Idaho or Oregon county;

(d) The replacement kidney ((~~dialysis facility~~)) disease treatment center will be located in the same county or planning area as the current Washington state ((~~facility~~)) center;

(e) Both existing kidney ((~~dialysis facilities~~)) disease treatment centers cease operation;

(f) There is no break in service between the closure of the existing kidney ((~~dialysis facilities~~)) disease treatment centers and the operation of the replacement ((~~facility~~)) center;

(g) There has been no change in ownership of either the Washington kidney ((~~dialysis facility~~)) disease treatment center or out-of-

state kidney ((~~dialysis facility~~)) disease treatment center for at least five years prior to applying for the exemption under this section;

(h) Each existing kidney ((~~dialysis facility~~)) disease treatment center has been operated by the current provider for a minimum of five years prior to applying for the exemption under this section;

(i) Each existing kidney ((~~dialysis facility~~)) disease treatment center has been operating at its current location for a minimum of five years prior to applying for the exemption under this section;

(j) The department has not granted a previous exemption under the provisions of this section; and

(k) The number of stations at the replacement kidney ((~~dialysis facility~~)) disease treatment center does not exceed the total of:

(i) All stations from the Washington state kidney ((~~dialysis facility~~)) disease treatment center; and

(ii) Using the 4.8 patients per station standard, the stations necessary for the number of patients receiving dialysis at the out-of-state kidney ((~~dialysis facility~~)) disease treatment center as reported on the most recent ((~~Northwest Renal~~)) Network quarterly modality report.

(2) Once a Washington state provider has requested and received its one-time exemption under the provisions of this section, the kidney ((~~dialysis facility's~~)) disease treatment center's "resident in-center patient" will have the same meaning as all patients at the ((~~facility~~)) center.

WSR 24-18-019
PERMANENT RULES
HEALTH CARE AUTHORITY
[Filed August 23, 2024, 8:43 a.m., effective September 23, 2024]

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

Purpose: The health care authority is amending this rule to update medical equipment, supplies, and appliances definitions to better clarify billing and coverage.

Citation of Rules Affected by this Order: Amending WAC 182-543-1000.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Adopted under notice filed as WSR 24-14-039 on June 26, 2024.

Changes Other than Editing from Proposed to Adopted Version:

Proposed/Adopted	WAC Subsection	Reason
WAC 182-543-1000		
Proposed	N/A	Adding a definition for the term "hospital bed" based on stakeholder comment.
Adopted	**Hospital bed:** A bed designed for use in a hospital or similar facility, or for use at home. It is characterized by its adjustability and various features, including the ability to elevate or lower the head, foot, or entire bed frame, often using a motorized mechanism. Hospital beds may also have side rails and other features to support patient care and comfort. They are used to provide patients with therapeutic support and to facilitate easier medical care and treatment.	

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

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

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

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

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

Date Adopted: August 23, 2024.

Wendy Barcus
Rules Coordinator

OTS-5384.2

AMENDATORY SECTION (Amending WSR 18-24-021, filed 11/27/18, effective 1/1/19)

WAC 182-543-1000 Definitions. The following definitions and abbreviations and those found in chapter 182-500 WAC apply to this chapter.

"By-report (BR)" - See WAC 182-500-0015.

"Complex needs patient" - An individual with a diagnosis or medical condition that results in significant physical or functional needs and capacities.

"Complex rehabilitation technology (CRT)" - Wheelchairs and seating systems classified as durable medical equipment within the medicare program that:

(a) Are individually configured for individuals to meet their specific and unique medical, physical, and functional needs and capacities for basic activities as medically necessary to prevent hospitalization or institutionalization of a complex needs patient;

(b) Are primarily used to serve a medical purpose and generally not useful to a person in the absence of an illness or injury; and

(c) Require certain services necessary to allow for appropriate design, configuration, and use of such item, including patient evaluation and equipment fitting.

"Date of delivery" - The date the client actually took physical possession of an item or equipment.

"Digitized speech" (also referred to as devices with whole message speech output) - Words or phrases that have been recorded by an individual other than the speech generating device (SGD) user for playback upon command of the SGD user.

"Disposable supplies" - Supplies which ((~~may be used once, or more than once, but are time limited~~)) are designed as single-use products to be discarded after initial use.

"EPSDT" - See WAC 182-500-0030.

"Expedited prior authorization (EPA)" - See WAC 182-500-0030.

"Fee-for-service (FFS)" - See WAC 182-500-0035.

"Health care common procedure coding system (HCPCS)" - A coding system established by the Health Care Financing Administration (HCFA) to define services and procedures. HCFA is now known as the Centers for Medicare and Medicaid Services (CMS).

"Home" - For the purposes of this chapter, means location, other than hospital or skilled nursing facility where the client resides and receives care.

"Hospital bed" - A bed designed for use in a hospital or similar facility, or for use at home. It is characterized by its adjustability and various features, including the ability to elevate or lower the head, foot, or entire bed frame, often using a motorized mechanism. Hospital beds may also have side rails and other features to support patient care and comfort. They are used to provide patients with therapeutic support and to facilitate easier medical care and treatment.

"House wheelchair" - A skilled nursing facility wheelchair that is included in the skilled nursing facility's per-patient-day rate under chapter 74.46 RCW.

"Individually configured" - A device has a combination of features, adjustments, or modifications specific to a complex needs patient that a qualified complex rehabilitation technology supplier provides by measuring, fitting, programming, adjusting, or adapting the device as appropriate so that the device is consistent with an assessment or evaluation of the complex needs patient by a health care professional and consistent with the complex needs patient's medical condition, physical and functional needs and capacities, body size, period of need, and intended use.

"Manual wheelchair" - See "Wheelchair - Manual."

"Medical equipment" - Includes medical equipment and appliances, and medical supplies.

"Medical equipment and appliances" - Health care-related items that:

(a) Are primarily and customarily used to serve a medical purpose;

(b) Generally, are not useful to a person in the absence of a disability, illness, or injury;

(c) Can withstand repeated use;

(d) Can be reusable or removable; and

(e) Are suitable for use in any setting where normal life activities take place.

"Medical supplies" - Health care-related items that are:

(a) Consumable or disposable or cannot withstand repeated use by more than one person;

(b) Required to address an individual medical disability, illness, or injury;

(c) Suitable for use in any setting which is not a medical institution and in which normal life activities take place; and

(d) Generally not useful to a person in the absence of illness or injury.

"Medically necessary" - See WAC 182-500-0070.

"National provider indicator (NPI)" - See WAC 182-500-0075.

"Orthotic device" or **"orthotic"** - A corrective or supportive device that:

(a) Prevents or corrects physical deformity or malfunction; or

(b) Supports a weak or deformed portion of the body.

"Power-drive wheelchair" - See "Wheelchair - Power."

"Pricing cluster" - A group of manufacturers' list prices for brands/models of medical equipment that the agency considers when calculating the reimbursement rate for a procedure code that does not have a fee established by medicare.

"Prior authorization" - See WAC 182-500-0085.

"Prosthetic device" or **"prosthetic"** - See WAC 182-500-0085.

"Qualified complex rehabilitation technology supplier" - A company or entity that:

(a) Is accredited by a recognized accrediting organization as a supplier of CRT;

(b) Meets the supplier and quality standards established for durable medical equipment suppliers under the medicare program;

(c) For each site that it operates, employs at least one CRT professional, certified by the rehabilitation engineering and assistive technology society of North America as an assistive technology professional, to analyze the needs and capacities of clients, and provide training in the use of the selected covered CRT items;

(d) Has the CRT professional physically present for the evaluation and determination of the appropriate individually configured CRT for the complex needs patient;

(e) Provides service and repairs by qualified technicians for all CRT products it sells; and

(f) Provides written information to the complex needs patient at the time of delivery about how the individual may receive service and repair of the delivered CRT.

"Resource-based relative value scale (RBRVS)" - A scale that measures the relative value of a medical service or intervention, based on the amount of physician resources involved.

"Reusable supplies" - Supplies which are ((~~to be used more than once~~)) designed and intended for repeated use.

"Safety enclosure frame/canopy" - A passive bed enclosure that provides a solid framework and a soft canopy structure, which securely attaches to the bed. The enclosure provides access to the client through openings, allowing the caregiver the ability to provide routine care to the client. It is an integral part of, or accessory to, a hospital bed.

"Scooter" - A federally approved, motor-powered vehicle that:

(a) Has a seat on a long platform;

(b) Moves on either three or four wheels;

(c) Is controlled by a steering handle; and

(d) Can be independently driven by a client.

"Specialty bed" - A hospital bed used primarily in the treatment of individuals with a disability, illness, or injury, that has a pressure reducing or relieving support surface, or both, such as foam, air, water, or gel mattress or overlay.

"Speech generating device (SGD)" - An electronic device or system that compensates for the loss or impairment of a speech function due to a congenital condition, an acquired disability, or a progressive neurological disease. The term includes only that equipment used for the purpose of communication. Formerly known as "augmentative communication device (ACD)."

"Synthesized speech" - Is a technology that translates a user's input into device-generated speech using algorithms representing linguistic rules, unlike prerecorded messages of digitized speech. A SGD that has synthesized speech is not limited to prerecorded messages but rather can independently create messages as communication needs dictate.

"Three- or four-wheeled scooter" - A three- or four-wheeled vehicle meeting the definition of scooter (see "scooter") and which has the following minimum features:

(a) Rear drive;

(b) A ((~~twenty-four~~)) 24 volt system;

(c) Electronic or dynamic braking;

(d) A high to low speed setting; and

(e) Tires designed for indoor/outdoor use.

"Trendelenburg position" - A position in which the patient is lying on his or her back on a plane inclined ((~~thirty to forty~~)) 30 to 40 degrees. This position makes the pelvis higher than the head, with the knees flexed and the legs and feet hanging down over the edge of the plane.

"Usual and customary charge" - See WAC 182-500-0110.

"Warranty-period" - A guarantee or assurance, according to manufacturers' or provider's guidelines, of set duration from the date of purchase.

"Wheelchair - Manual" - A federally approved, nonmotorized wheelchair that is capable of being independently propelled and fits one of the following categories:

(a) Standard:

(i) Usually is not capable of being modified;

(ii) Accommodates a person weighing up to ((~~two hundred fifty~~)) 250 pounds; and

(iii) Has a warranty period of at least one year.

(b) Lightweight:

(i) Composed of lightweight materials;

(ii) Capable of being modified;

(iii) Accommodates a person weighing up to ((~~two hundred fifty~~)) 250 pounds; and

(iv) Usually has a warranty period of at least three years.

(c) High-strength lightweight:

(i) Is usually made of a composite material;

(ii) Is capable of being modified;

(iii) Accommodates a person weighing up to ((~~two hundred fifty~~)) 250 pounds;

(iv) Has an extended warranty period of over three years; and

(v) Accommodates the very active person.

(d) Hemi:

(i) Has a seat-to-floor height lower than ((~~eighteen~~)) 18 inches to enable an adult to propel the wheelchair with one or both feet; and

(ii) Is identified by its manufacturer as "Hemi" type with specific model numbers that include the "Hemi" description.

(e) Pediatric: Has a narrower seat and shorter depth more suited to pediatric patients, usually adaptable to modifications for a growing child.

(f) Recliner: Has an adjustable, reclining back to facilitate weight shifts and provide support to the upper body and head.

(g) Tilt-in-space: Has a positioning system, which allows both the seat and back to tilt to a specified angle to reduce shear or allow for unassisted pressure releases.

(h) Heavy duty:

(i) Specifically manufactured to support a person weighing up to ((~~three hundred~~)) 300 pounds; or

(ii) Accommodating a seat width of up to ((~~twenty-two~~)) 22 inches wide (not to be confused with custom manufactured wheelchairs).

(i) Rigid: Is of ultra-lightweight material with a rigid (nonfolding) frame.

(j) Custom heavy duty:

(i) Specifically manufactured to support a person weighing over ((~~three hundred~~)) 300 pounds; or

(ii) Accommodates a seat width of over ((~~twenty-two~~)) 22 inches wide (not to be confused with custom manufactured wheelchairs).

(k) Custom manufactured specially built:

(i) Ordered for a specific client from custom measurements; and

(ii) Is assembled primarily at the manufacturer's factory.

"Wheelchair - Power" - A federally approved, motorized wheelchair that can be independently driven by a client and fits one of the following categories:

(a) Custom power adaptable to:

(i) Alternative driving controls; and

(ii) Power recline and tilt-in-space systems.

(b) Noncustom power: Does not need special positioning or controls and has a standard frame.

(c) Pediatric: Has a narrower seat and shorter depth that is more suited to pediatric patients. Pediatric wheelchairs are usually adaptable to modifications for a growing child.

WSR 24-18-040
PERMANENT RULES
DEPARTMENT OF
SOCIAL AND HEALTH SERVICES
(Developmental Disabilities Administration)
[Filed August 27, 2024, 8:22 a.m., effective October 7, 2024]

Effective Date of Rule: October 7, 2024.

Purpose: The developmental disabilities administration (DDA) amended these rules to implement 2SHB 2008, which directs DDA to remove intelligence quotient (IQ) criteria from DDA enrollment processes. Additional changes have been made to combine and repeal redundant sections in the chapter, clarify language, and update intake and eligibility processes.

Citation of Rules Affected by this Order: New WAC 388-823-0620 and 388-823-0630; repealing WAC 388-823-0720, 388-823-0730, 388-823-0770, 388-823-0940, 388-823-1000, 388-823-1030, 388-823-1090 and 388-823-1100; and amending WAC 388-823-0010, 388-823-0015, 388-823-0020, 388-823-0025, 388-823-0055, 388-823-0075, 388-823-0090, 388-823-0100, 388-823-0105, 388-823-0115, 388-823-0200, 388-823-0210, 388-823-0300, 388-823-0310, 388-823-0400, 388-823-0410, 388-823-0500, 388-823-0510, 388-823-0600, 388-823-0610, 388-823-0740, 388-823-0750, 388-823-0760, 388-823-0910, 388-823-0920, 388-823-0930, 388-823-1005, 388-823-1010, 388-823-1060, 388-823-1070, and 388-823-1080.

Statutory Authority for Adoption: RCW 71A.10.020, 71A.16.020, and 74.08.090.

Other Authority: RCW 71A.10.020, 71A.16.020, and 74.08.090.

Adopted under notice filed as WSR 24-13-080 on June 17, 2024.

Changes Other than Editing from Proposed to Adopted Version: In WAC 388-823-0500, DDA changed "naturopath" to "naturopathic physician" to make use of the language used by the industry and professionals themselves.

In WAC 388-823-0300, 388-823-0600, and 388-823-0630, DDA added "naturopathic physician" as requested by community partners.

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

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 6, Repealed 2.

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

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

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 2, Amended 25, Repealed 6.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 2, Amended 31, Repealed 8.

Date Adopted: August 27, 2024.

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 24-19 issue of the Register.

WSR 24-18-046
PERMANENT RULES
MILITARY DEPARTMENT
(Emergency Management Division)
[Filed August 27, 2024, 11:39 a.m., effective September 27, 2024]

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

Purpose: The purpose is to establish eligibility, activation, funding, and programmatic criteria for a Washington state disaster individual assistance (WAIA) program. The WAIA program is designed to provide supplemental state assistance for disaster survivors. Funding is issued through reimbursements to eligible county and/or tribal governments for all nonspecial programs. Special programs are issued in the form of grants to eligible county and/or tribal governments.

Citation of Rules Affected by this Order: New chapter 118-11 WAC.

Statutory Authority for Adoption: RCW 38.52.030(9) and 38.52.050.

Adopted under notice filed as WSR 24-11-027 on May 7, 2024.

Changes Other than Editing from Proposed to Adopted Version: WAC 118-11-020 changed wording under purpose and intent; removed the strikethrough section to keep WAC flexible for future potential changes to the program process.

WAC 118-11-030 under definitions subsection (16) Proof of residency, added *(j) Document Exception: Proof of Occupancy - If the listed documentation is unavailable, the State may accept a written self-declarative statement as a last resort. The statement must include how long the applicant lived in the disaster-damaged residence prior to the disaster, an explanation of the circumstances that prevent standard occupancy verification, and the applicant's signature. The self-declarative statement may be written post-disaster.*

WAC 118-11-050 under program activation criteria, added subsection (b) The governor has issued an emergency proclamation with language directing, ordering, and authorizing the director of the Washington military department, emergency management division, to initiate the state IA program in the impacted jurisdiction(s) *with the exception of disasters where there is a Tribal Emergency Proclamation;*

- Corrected language under Scenario 1.
- Updated Scenario 2 to state that survivors may apply to SBA at the same time they apply for state IA assistance.
- Updated language under subsection (3) to include tribal lands.

WAC 118-11-070 Removed SBA criteria under general eligibility.

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

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

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

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

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

Date Adopted: August 27, 2024.

Taylor Dietz, Supervisor
Human Services Program

OTS-5404.1

Chapter 118-11 WAC
STATE DISASTER INDIVIDUAL ASSISTANCE PROGRAM

NEW SECTION

WAC 118-11-010 Authority. The authority for this chapter is RCW 38.52.030(9), which authorizes the director of the Washington military department, emergency management division, to prepare and administer a state program for emergency assistance to individuals within the state who are victims of a natural, technological, or human-caused disaster.

NEW SECTION

WAC 118-11-020 Purpose and intent. The purpose of this chapter is to establish eligibility, activation, funding, and programmatic criteria for a Washington state disaster individual assistance (IA) program. The state IA program is designed to provide supplemental state assistance for disaster survivors. Assistance to businesses damaged, destroyed, or otherwise closed due to a disaster or for individuals to replace lost wages caused by a disaster are ineligible for the IA program. Funding is issued through reimbursements to eligible county or tribal governments for most aspects of the state IA program. Assistance is provided from the eligible county or tribal government directly to the eligible individuals, with support provided as needed by the Washington military department, emergency management division. The extended sheltering assistance and disaster case management programs are issued in the form of grants to eligible county or tribal governments.

NEW SECTION

WAC 118-11-030 Definitions. The definitions in this section apply throughout this title unless the context clearly requires otherwise.

(1) "Applicant" means an individual applying to the state IA program. An applicant may apply for a disaster survivor on the survivor's behalf.

(2) "Department" means Washington military department, emergency management division.

(3) "Destroyed" means a residence that is a total loss per FEMA PDA guidance.

(4) "Disaster" means an event or set of circumstances which:

(a) Demands immediate action to preserve public health, protect public property, or to provide relief to any stricken community overtaken by such occurrences; or

(b) Reaches such a dimension or degree of destructiveness as to warrant the governor proclaiming a state of emergency pursuant to RCW 43.06.010.

(5) "FEMA" means the Federal Emergency Management Agency, the lead federal agency in responding to and recovering from disasters across the United States.

(6) "Functional" means a residence that is fit for standard use by its occupants for the purposes of performing activities of daily living.

(7) "Habitable" means a residence that is safe, sanitary, functional, and presents no disaster-caused hazards to the occupants.

(8) "Home" or "residence" means the physical location of the damaged primary residence caused by a disaster.

(9) "Home repair assistance" means financial assistance for repairs to make a residence habitable and may include repairs to the structure, utilities, or privately owned access routes.

(10) "Home replacement assistance" means financial assistance to help replace a primary residence when the residence has been destroyed by a disaster. Home replacement assistance is only provided to restore an applicant's living conditions to a safe, functional, and accessible state.

(11) "Household" means all persons who lived in a residence before a disaster.

(12) "Inaccessible" means a residence in which damage to the structure cannot be visually inspected or verified because of disaster-related loss of access.

(13) "Incident period" means the duration of time during which sustained and concentrated disaster impacts occurred.

(14) "Major damage" means a residence with structural damage or other significant damage that requires extensive repairs per FEMA PDA guidance.

(15) "Primary residence" means the residence where the survivor normally lives during the major portion of the calendar year, or the residence that is required because of proximity to employment, including agricultural activities that provide 50 percent or more of the household's income.

(16) "Proof of residency" means any document establishing that a survivor is a resident of a county or tribal nation that has declared a state of emergency. Proof of residency, which must be dated within one year prior to the disaster or within the period of assistance, may include, but is not limited to, the following documents:

(a) Bills (utility, financial documents, other);

(b) Employer documents (pay stubs or similar);

(c) Lease/housing agreement/mortgage statement or rent receipts;

(d) Identification card;

(e) Client record from a social service organization;

(f) School registration;

(g) Federal or state benefit record;

(h) Motor vehicle registration; and

(i) Official legal documents, including subpoenas and other court orders.

(17) "Recipient" means a survivor found eligible to receive state IA program grants.

(18) "Rental assistance" means financial assistance to rent temporary housing accommodations while a survivor is displaced from a primary residence.

(19) "State IA program" means the Washington state individual assistance program, authorized under RCW 38.52.030(9) and administered by the Washington military department, emergency management division (WA EMD).

(20) "Survivor" means a person who has been displaced from their residence or otherwise affected by a declared disaster event. The survivor is the recipient of the state IA program funds when determined eligible through the application process.

(21) "Tribal/tribe/tribal government/nation" means a federally recognized Indian tribe in Washington state.

NEW SECTION

WAC 118-11-040 Funding. Amounts awarded under the state IA program are limited to allocations made available to the Washington military department, emergency management division, for the Washington state disaster individual assistance program each state fiscal year.

NEW SECTION

WAC 118-11-050 Program activation criteria. (1) The state of Washington will activate the state IA program in the event all the following criteria are met:

(a) A county or tribal government declaration or state of emergency has been issued;

(b) The governor has issued an emergency proclamation with language directing, ordering, and authorizing the director of the Washington military department, emergency management division, to initiate the state IA program in the impacted jurisdiction(s);

(c) A joint damage assessment confirms a minimum of 25 primary homes in the area of greatest impact sustained damages categorized as "major" or "destroyed" according to the FEMA damage assessment criteria. This threshold can be met by considering the cumulative impact of multiple counties and tribal governments, if necessary;

(d) A county or tribal government has requested joint damage assessments directly to the state within 14 calendar days after the end of the incident period, as determined by the department; and

(e) A county commissioner, tribal government executive, or authorized designee has requested state IA program activation. The department will start accepting applications after the director of the Washington military department signs the activation request.

(2) Three scenarios are possible to initiate the state IA program in a jurisdiction.

(a) Scenario 1: Washington state has received no federal assistance.

(i) Cumulatively, more than 25 homes have "major" or "destroyed" damage categories across multiple counties or tribal lands;

(ii) Voluntary organizations active in disaster are supporting disaster survivors;

(iii) The state's request for a U.S. Small Business Administration (SBA) disaster declaration has been denied or the state has not met the threshold to apply for SBA assistance; and

(iv) The state IA program is activated to support eligible disaster survivors.

(b) Scenario 2: Washington state has received only SBA assistance and the disaster does not warrant a Presidential Major Disaster Declaration authorizing FEMA's Individuals and Households Program or the state's request for FEMA IA was denied.

(i) At least 25 homes have "major" or "destroyed" damage categories in one county or tribal land;

(ii) Voluntary organizations active in disaster are supporting disaster survivors;

(iii) The state IA program is activated to support eligible disaster survivors through the Household Needs Grant;

(iv) The state's request for an SBA disaster declaration has been approved; and

(v) The state IA program is activated to support eligible disaster survivors. Disaster survivors must first apply to the SBA for a disaster loan except to access the household needs grant and extended sheltering assistance state IA programs.

(c) Scenario 3: Washington state has received both an SBA disaster declaration and a Presidential Major Disaster Declaration authorizing FEMA's Individuals and Households Program.

(i) At least 25 homes have "major" or "destroyed" damage categories in one county or tribal land. In this scenario, the damage profile will likely greatly exceed 25 homes with "major" or "destroyed" damage categories to warrant both FEMA and SBA assistance;

(ii) Voluntary organizations active in disaster are supporting disaster survivors;

(iii) The state's request for a Presidential Major Disaster Declaration authorizing FEMA's Individuals and Households Program has been approved;

(iv) The state's request for an SBA disaster declaration has been approved; and

(v) The state IA program is activated to support eligible disaster survivors and address any remaining disaster-caused unmet needs not covered by federal assistance or any other means.

(3) Multicounty impacted areas are allowable to reach the minimum 25 primary home threshold. The area of greatest impact will be determined by the Washington state emergency management division and derived from National Weather Service reports and county, tribal, or state government official damage assessments or reports.

(4) The incident period is determined by the department and may be adjusted with good cause. The incident start and end date may include, but is not limited to, National Weather Service warnings, level 3 "go now!" evacuation level notices, and the impacted jurisdiction's community lifeline status, including safety and security, food, hydration, shelter, health and medical, energy, communications, transportation, hazardous materials, and water systems.

NEW SECTION

WAC 118-11-060 Application process. (1) **Applications.** Applications for state IA program funds may be accepted in the following ways:

(a) In person (disaster recovery center, disaster loan outreach center, multiagency resource center, etc.);

(b) By phone (call center/disaster assistance hotline);
(c) Online; or
(d) U.S. mail/paper (then entered by staff into the online system).

(2) **Application reviews.** Two types of application reviews are possible under the state IA program to approve or deny applications: Initial review and advanced review.

(a) Initial review. Occurs upon receipt of the application and represents the standard decision process for most applications. Initial review is performed by a local or tribal government disaster case worker and the county or tribal government designated IA officer.

(b) Advanced review. Intended to support decisions for complex applications or those needing additional review. Advanced review is performed by the state IA branch director and the state coordinating officer.

(3) **Application period.**

(a) The application period deadline is 60 calendar days from the date of the initial public notice.

(b) The department may accept late applications beyond the original application deadline.

(c) The application period for late applications shall be 30 days after the initial deadline. The department reserves the option to further extend the late application period for good cause.

NEW SECTION

WAC 118-11-070 Disaster types eligible for assistance. Disaster types eligible for assistance are identified in the Washington state enhanced hazard mitigation plan.

NEW SECTION

WAC 118-11-080 Types of assistance. (1) The award amounts and maximum awards for each program category are defined annually by the Washington military department and outlined in the department's state IA program administrative plan. Maximum awards for the housing assistance and household needs assistance programs align with FEMA's Individuals and Households Program maximum awards, determined annually by the federal government. The categories of programs offered under the Washington state disaster individual assistance program include the following:

(a) Housing assistance;
(b) Rental assistance;
(c) Home repair assistance;
(d) Home replacement assistance.

(2) **Household needs grant.** Award based on household size and verified damage categories "destroyed" or "major."

(3) **Household needs assistance.**

(a) Medical/dental assistance;
(b) Funeral assistance;
(c) Childcare assistance;
(d) Transportation assistance (repair or replace);
(e) Other, based on needs.

(4) **Special programs.**
(a) Extended sheltering assistance (ESA);
(b) Disaster case management (DCM).

NEW SECTION

WAC 118-11-090 Survivor and local or tribal government responsibilities. (1) Declared counties or tribal governments must have a signed opt-in grant agreement with the state in place prior to activation. A completed state IA grant agreement between the impacted jurisdiction and the Washington military department with incident-specific information will be finalized at program activation.

(2) County or tribal governments requesting extended sheltering assistance must have a shelter transition plan in place to receive funding for that program.

(3) Survivors receiving continued rental assistance or extended sheltering assistance must provide evidence of continued displacement and progress on a permanent housing plan.

NEW SECTION

WAC 118-11-100 Applicant general eligibility. (1) To be eligible for state IA program assistance, recipients must meet all general eligibility requirements provided in this section in addition to any program-specific requirements.

(2) To apply for the state IA program, the applicant or survivor must:

(a) Be a resident of a county or tribal nation that has declared a state of emergency.

(b) If insured against the peril under, without limitation, a flood, homeowners, vehicle, mobile home, or health insurance policy, show proof of insurance and any claim settlement information related to the disaster-caused needs.

(c) Present evidence of damages that are attributed to the declared disaster including, but not limited to, proof that the primary residence was destroyed, sustained major damage, or is rendered inaccessible. Such proof may include the following without limitation:

(i) Evidence that essential living areas in the residence have sustained major damage;

(ii) Evidence that essential living areas in the residence have been destroyed and pose serious health or safety hazards; or

(iii) Evidence that the survivor is displaced due to the home being rendered inaccessible.

(d) Provide proof of disaster assistance received from any other entity for this event (to avoid duplication of benefits), such as receipt of assistance from the department of social and health services' disaster cash assistance program.

(e) Have a household income equal to or less than 80 percent of the Housing and Urban Development (HUD) area median household income for the calendar year prior to the disaster, based on the number of persons in the household. HUD's area median income may include the county or nearest metropolitan statistical area (MSA) if it benefits the applicant.

(f) Apply for SBA assistance, if available. An application for SBA assistance is not required for household needs grant or extended sheltering assistance.

(i) Applicants who refuse an SBA loan if approved are ineligible for state IA program assistance.

(ii) If an SBA loan is approved and accepted by an applicant, an applicant may still be eligible for supplemental assistance provided by the state IA program.

(iii) State IA program assistance will only be provided to restore an applicant's living conditions to a safe, functional, and accessible state.

NEW SECTION

WAC 118-11-110 Appeals and reconsiderations. Impacted jurisdictions that have entered into a state IA program grant agreement with the department must allow survivors applying for assistance an opportunity to appeal and allow for reconsideration of application denials as provided in this section.

(1) **Number of appeals.** In cases where the application has been denied by the county or tribal disaster case worker, survivors may appeal determinations twice.

(2) **Deadline to appeal.** All deadlines provided in this subsection may be extended by the county or tribal IA appeal officer or by the department for good cause.

(a) First appeal: A survivor must be provided 30 calendar days from the date on the survivor's notification letter to appeal. The survivor's appeal must be postmarked on a physical submission or date-marked on an electronic submission.

(b) Second appeal: If the first appeal is denied, the survivor must be provided an additional 30 calendar days from the date on the appeal denial notification letter to submit a second appeal.

(3) **Appeal review process.** The declared county or tribal government must designate a person to serve as the county or tribal IA appeal officer. All deadlines provided in this subsection may be extended by the county or tribal IA appeal officer or by the department for good cause.

(a) First appeal: The county or tribal IA appeal officer shall review the appeal and eligibility, make a recommendation, and send the recommendation to the department IA program staff for review and approval. The department must issue a decision granting or denying the appeal within 30 calendar days from date of receipt from the appeal officer.

(b) Second appeal: The county or tribal government must send the second appeal package to the department IA program staff. Department IA program staff will review the second appeal and send the package with a recommendation to the state coordinating officer for final determination. The department must issue a decision granting or denying the appeal within 30 calendar days from date of receipt from the appeal officer.

(4) **Reconsiderations.**

(a) In cases where a survivor was approved for assistance but needs additional assistance and has not yet reached a maximum award for the program category under review, the survivor may submit a reconsideration request up to the maximum award for that program catego-

ry if the survivor can provide documentation demonstrating the need for additional assistance.

(b) To process a reconsideration, the local or tribal government disaster case worker reviews the package to determine if the survivor is eligible for additional assistance and works with the survivor to ensure that all necessary documentation is included in the package.

(c) If the survivor meets all general eligibility and program-specific requirements, the case worker then submits the package, confirming all eligibility requirements have been met, to the designated county or tribal IA appeals officer for final determination. If the survivor does not meet all general eligibility and program specific requirements, a determination letter is sent to the survivor by the county or tribal IA appeals officer, detailing which requirements were not met resulting in the ineligibility determination.

WSR 24-18-050
PERMANENT RULES
POLLUTION LIABILITY
INSURANCE AGENCY

[Filed August 27, 2024, 3:51 p.m., effective September 27, 2024]

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

Purpose: The purpose of this rule is to implement the state financial assurance program (program), as established in chapter 70A.545 RCW. The rule describes program enrollment eligibility, coverage, and administration for the remediation of contamination caused by releases from petroleum underground storage tanks.

As authorized by chapter 70A.545 RCW, the purpose of this rule is to establish criteria and procedures for the payment of costs from the program to remediate contamination caused by releases from petroleum underground storage tanks (UST). Remediation efforts are managed and directed by the Washington state pollution liability insurance agency (PLIA) to ensure that all petroleum cleanup meets the substantive requirements of the Model Toxics Control Act under chapter 70A.305 RCW and chapter 173-340 WAC. The rule establishes program eligibility and coverage limitations for owners or operators of commercial petroleum UST systems seeking an alternative financial responsibility mechanism. This program does not change any existing rules found in Title 374 WAC.

Citation of Rules Affected by this Order: New chapter 374-10 WAC, State financial assurance program.

Statutory Authority for Adoption: RCW 70A.545.100(1).

Adopted under notice filed as WSR 24-12-082 on June 4, 2024.

Changes Other than Editing from Proposed to Adopted Version: WAC 374-10-020, defined "facility"; in definition of "petroleum underground storage tank," replaced "tribal governments" with "other non-state regulating agency" in order to include all relevant regulating government bodies and expanded definition to make clear what was not included.

WAC 374-10-030 (2)(b), removed reference to federal government and tribal government and specified that registration of a UST must be with the either the Washington department of ecology or the United States Environmental Protection Agency (EPA). This was done after consultation with EPA staff regarding the proper authority for registration of UST on federal or tribal-governed land.

WAC 374-10-040 (1)(b)(i) and (ii), same edit as in WAC 374-10-030 (2)(b).

WAC 374-10-040 (1)(b)(i) and (iii), "agreed order" was replaced with "any order" for clarification purposes.

WAC 374-10-050 (1)(b), similar edit to WAC 374-10-030 (2)(b).

WAC 374-10-050(3), changed effective date of cancellation from 45 days after receiving written notice to 60 days in order to meet federal requirements.

WAC 374-10-060 (1)(a), changed description of priority of third-party claim funding to meet federal requirements.

WAC 374-10-070 (2), (3), and (4), similar edit to WAC 374-10-030 (2)(b).

WAC 374-10-070(7), listed the federal regulation that governs petroleum releases in Indian Country.

WAC 374-10-070(9), altered "will result in cancellation" to "may result in cancellation" for failure to meet PLIA cleanup timelines. The program will allow participants to correct violations before can-

cellation; "will" cancel was the wrong language to use to describe that process.

WAC 374-10-080(1), added that evidence to establish the date of a release must be "clear, cogent, and convincing." This standard applied under the previously submitted version of the rule. It was added here for clarification.

WAC 374-10-080(5), this is a clarification that funding for infrastructure replacement is only available for remediation activities for releases from USTs that are already enrolled in the program.

WAC 374-10-090 (2)(b), added additional clarification that costs must be approved by the PLIA to be reimbursable.

WAC 374-10-090 (2)(g), removed eligibility for infrastructure replacement spending during remediation of preenrollment releases.

WAC 374-10-090 (3)(a), (b), and (c), similar edit to WAC 374-10-030 (2)(b).

WAC 374-10-130(4), clarified that all parties participating in the program must produce relevant records when requested by PLIA.

WAC 374-10-140(4), same change as in WAC 374-10-050(3), changing effective date of cancellation and time to appeal from 45 days to 60.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 14, Amended 0, Repealed 0.

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

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

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

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

Date Adopted: August 27, 2024.

Phi V. Ly
Legislative and Policy Manager

OTS-5288.3

Chapter 374-10 WAC
STATE FINANCIAL ASSURANCE PROGRAM

NEW SECTION

WAC 374-10-010 Purpose. As authorized by chapter 70A.545 RCW, the purpose of this chapter is to establish criteria and procedures for the payment of costs from the state financial assurance program to address a release from petroleum underground storage tank systems. The agency will administer the program with a focus on release prevention and remediation and the equitable protection of human health and the

environment. The program allows petroleum underground storage tank owners and operators to meet financial responsibility requirements.

NEW SECTION

WAC 374-10-020 Definitions. Unless the context requires otherwise, the definitions in this section shall apply throughout this chapter.

(1) "Agency" means the Washington state pollution liability insurance agency and may be referred to as PLIA throughout this chapter. For purposes of chapter 70A.545 RCW, agency or PLIA shall also mean staff or employees of the pollution liability insurance agency.

(2) "Bodily injury" means actual medically documented costs and medically documentable future costs of adverse health effects that have resulted from exposure to a release from a petroleum underground storage tank. The term does not include pain and suffering.

(3) "Director" means the director or designee of the Washington state pollution liability insurance agency.

(4) "Enrollment" or "enrolled" means the status of a petroleum underground storage tank where it has been accepted by the agency into the state financial assurance program, the enrollment agreement has been signed and payment for the program has been made by the owner or operator of the eligible petroleum underground storage tank.

(5) "Facility" means the property where the enrolled tank is located, including any infrastructure within that property. For purposes of this program, facility does not have the same meaning as WAC 173-340-200.

(6) "Facility assessment" means an evaluation of a petroleum underground storage tank, its system, or the facility.

(7) "Financial assurance request" means a request for payment from the state financial assurance program filed by an owner or operator of an enrolled petroleum underground storage tank.

(8) "MTCA" means the Model Toxics Control Act (chapter 70A.305 RCW).

(9) "Online community" means the cloud-based application and data system used by the agency to submit documentation and to report, process, and look up project information.

(10) "Owner or operator" means the entity in control of, or having a responsibility for, the daily operation of a petroleum underground storage tank.

(11) "Petroleum" means any petroleum-based substance, including crude oil or any fraction that is liquid at standard conditions of temperature and pressure. "Petroleum" includes, but is not limited to, petroleum and petroleum-based substances comprised of a complex blend of hydrocarbons, such as motor fuels, jet fuels, distillate fuel oils, residual fuel oils, lubricants, petroleum solvents, and used oils. The term does not include propane, asphalt, or any other petroleum product that is not liquid at standard conditions of temperature and pressure. Standard conditions of temperature and pressure are at 60 degrees Fahrenheit and 14.7 pounds per square inch absolute.

(12) "Petroleum underground storage tank" means an underground storage tank regulated under chapter 70A.355 RCW or subtitle I of the Solid Waste Disposal Act (42 U.S.C. chapter 82, subchapter IX) that is used for storing petroleum. This includes tanks owned or operated on property under the direct jurisdiction of either the federal govern-

ment or governments other nonstate regulating agency. This term does not include any:

(a) Farm or residential tank of 1,100 gallons or less capacity used for storing motor fuel for noncommerical purposes;

(b) Tank used for storing heating oil for consumptive use on the premises where stored;

(c) Septic tank;

(d) Pipeline facility (including gathering lines):

(i) Which is regulated under 49 U.S.C. chapter 601; or

(ii) Which is an intrastate pipeline facility regulated under state laws as provided in 49 U.S.C. chapter 601, and which is determined by the Secretary of Transportation to be connected to a pipeline, or to be operated or intended to be capable of operating at pipeline pressure or as an integral part of a pipeline;

(e) Surface impoundment, pit, pond, or lagoon;

(f) Storm water or wastewater collection system;

(g) Flow-through process tank;

(h) Liquid trap or associated gathering lines directly related to oil or gas production and gathering operations;

(i) Storage tank situated in an underground area (such as a basement, cellar, mineworking, drift, shaft, or tunnel) if the storage tank is situated upon or above the surface of the floor;

(j) Tank owned by the federal government or located on a federal military installation or federal military base; or

(k) Tank located within the Hanford Site.

(13) "Petroleum underground storage tank facility" means the location where the petroleum underground storage tank and its system is located. The term encompasses all real property under common ownership associated with the operation of the petroleum underground storage tank.

(14) "Petroleum underground storage tank system" means an underground storage tank, connected underground piping, underground ancillary equipment, and containment system, if any.

(15) "Prime consultant" means an environmental consultant or business contracted by the agency to perform remediation under the program.

(16) "Program" means the state financial assurance program established by chapter 70A.545 RCW.

(17) "Property damage" means a documented adverse physical impact to structures or property resulting from a release from a petroleum underground storage tank. The term does not include business income whose loss is related to the petroleum release or remediation activities.

(18) "Release" has the same meaning as defined in RCW 70A.305.020.

(19) "Remedial action" or "remedy" has the same meaning as defined in RCW 70A.305.020.

(20) "Site" has the same meaning as "facility" as defined in RCW 70A.305.020.

(21) "Third-party claim" means a claim for funds from the program by an injured party for bodily injury or property damages resulting from a release from an enrolled petroleum underground storage tank. The following entities are not considered a third party: A petroleum underground storage tank owner or operator from which the release occurred; the owner of the property where the petroleum underground storage tank is located; a person to whom properties are transferred

in anticipation of damage due to a release; employees or agents of the operator; or employees or agents of the property owner.

NEW SECTION

WAC 374-10-030 Eligibility for financial assurance. (1) To participate in the financial assurance program, the owner or operator of a petroleum underground storage tank must apply and the tank must be enrolled in the program. Enrollment is limited to a petroleum underground storage tank located in Washington. If the owner and operator of the petroleum underground storage tank are separate entities, only one entity at a time may enroll the tank.

(2) To be eligible to participate in the financial assurance program, the petroleum underground storage tank system must meet the following requirements:

(a) Maintain compliance with the requirements of chapter 173-360A WAC, Underground storage tank regulations or federal equivalent.

(b) Be registered with the department of ecology or the United States Environmental Protection Agency.

(3) An owner or operator of an enrolled petroleum underground tank determined to have committed fraud as described in WAC 374-10-130 is ineligible to later enroll that tank.

NEW SECTION

WAC 374-10-040 Application, enrollment, and fees. (1)(a) Applications for program enrollment are made using the agency's online community. If requested from the agency, alternative formats for application will be provided. The agency will review all applications for completeness. Incomplete applications will not be accepted.

(b) The application must include information on any known release from the petroleum underground storage tank system. If there has been such a release, to be considered for enrollment, one of the following requirements must be met and approved by the agency.

(i) The release has been reported to the department of ecology or other regulating agency as required, and remedial actions have been completed as an independent action or under any order or consent decree. For an independent action, the release and remedial actions have been reviewed by either the department of ecology's voluntary cleanup program or the agency's technical assistance program and a no further action letter has been issued. For remedial actions completed under any order or consent decree, the department of ecology must have issued a written determination that requirements of the order or decree have been met.

(ii) The release has been reported to the department of ecology or other regulating agency as required and independent remedial actions have been planned but not yet completed or independent remedial actions completed but without a no further action letter from the department of ecology's voluntary cleanup program or the agency's technical assistance program. The planned remedial actions must be reviewed by the agency prior to enrollment, and the independent cleanup must be entered into the agency's technical assistance program. A remedial action schedule with milestones will be part of the enrollment

agreement and must be adhered to for the tank to remain enrolled in the program.

(iii) The release has been reported to the department of ecology and remedial actions are required under an order or consent decree. The remedial action schedule in the order or consent decree must be adhered to for the tank to remain enrolled in the program.

(2) An enrolled petroleum underground storage tank may be randomly selected for a facility assessment performed by agency staff or agency-contracted consultant. Those selected for a facility assessment will be notified.

(3) The agency will notify the applicant if their application has been accepted for enrollment. The petroleum underground storage tank is considered enrolled in the program on the date that the agency signs the enrollment agreement.

(4) The agency will notify the applicant if their application has been denied. Denial of enrollment will be documented in writing.

(5) The enrollment term is 12 months, with coverage commencing on the enrollment date (the date the agency signs the enrollment agreement). Renewals occur on the same date each subsequent year and coverage is continuous unless the agency or the enrolled owner or operator cancels enrollment.

(6) The enrollment fee pays for the enrollment of a petroleum underground storage tank for a term of 12 months. Program participants may request a payment plan from the agency, but the entire enrollment fee amount must be paid to the agency within the 12-month enrollment term period. No refunds of the enrollment fee will be made, regardless of whether the petroleum underground storage tank coverage is canceled.

(7) The enrollment fees will be updated at least every four years and will be posted on the agency's website. The enrollment fee amount contributes to the agency's costs for program operations and administration.

(8) An enrollment fee may be discounted. Approved discounts are applied following the first year of enrollment on the renewal date for the second year of coverage and evaluated each subsequent year.

(9) Discounts may include, but are not limited to, the following factors:

(a) The age of the facility, individual petroleum underground storage tank system, and associated infrastructure;

(b) The physical condition of the facility; or

(c) Whether the owner or operator adheres to industry best practices for preventing releases from petroleum underground storage tanks.

NEW SECTION

WAC 374-10-050 Cancellation of enrollment. (1) The agency may cancel enrollment for any of the following reasons:

(a) Failure to maintain the petroleum underground storage tank system or petroleum underground storage tank facility to a standard established in the program policy or enrollment agreement;

(b) Failure to comply with remediation plans agreed to or required by a regulating agency;

(c) Refusal to allow the agency to conduct a facility assessment;

(d) Failure to meet any cleanup milestones listed and submitted with the enrollment agreement;

(e) Failure to notify the agency of a release from the enrolled petroleum underground storage tank;

(f) Failure to notify the agency of any notice of noncompliance or notice of violation issued by a regulatory agency;

(g) Failure to allow the agency access to the enrolled petroleum underground storage tank system;

(h) Failure to allow the agency to conduct remedial action(s) related to a release from the enrolled petroleum underground storage tank;

(i) Failure to fulfill terms of the enrollment agreement; or

(j) Fraud by any owner or operator, as described in WAC 374-010-130 regarding the enrolled petroleum underground storage tank.

(2) The agency will provide written notice of cancellation describing the reason(s) for cancellation to the owner or operator of the enrolled petroleum underground storage tank. As applicable, the written notice will identify how to remedy the issues leading to cancellation.

(3) Cancellation by the agency is effective 60 calendar days from the date of written notice. Coverage under the program will end on that effective date unless the cancellation is disputed.

(4) The owner or operator may dispute the cancellation by requesting a review of the agency decision as described in WAC 374-10-140 within 45 calendar days from notice of the cancellation.

(a) Coverage under the program will continue during the dispute review process.

(b) If, after the review of the dispute, the agency determines that a cancellation is still appropriate, cancellation is effective on the date indicated in the dispute review's written notice. Coverage under the program will end on that effective date.

(c) If the owner or operator seeks to appeal the agency's dispute review decision as allowed in WAC 374-10-140(4), the cancellation is still effective as of the date of the dispute review's written notice. Coverage under the program will not continue during the director review process.

(5) The owner or operator of an enrolled petroleum underground storage tank may request cancellation of enrollment at any time. Coverage will continue for the enrollment term, ending on the renewal date.

If the owner or operator uses another financial responsibility mechanism and requires coverage to address a release, this program's coverage is applied as secondary coverage.

(6) If an entity is no longer the owner or operator of the enrolled petroleum underground storage tank, then coverage under the program is canceled and the cancellation date is based on when the entity is no longer the owner or operator.

NEW SECTION

WAC 374-10-060 Financial assurance coverage. (1) Release from the petroleum underground storage tank after enrollment.

(a) The program will provide financial assurance funds of up to $2,000,000, per tank, for remedial action costs to address a release that occurs after enrollment from a petroleum underground storage tank

system, and any other petroleum releases which may be occurring simultaneously at the facility at which the petroleum underground storage tank is located.

A third-party claim will be distributed from these funds. PLIA will determine the timing of any eligible third-party claim payment.

(b) If there is a dispute with the agency determination on timing of the release, the owner or operator must show by clear, cogent, and convincing evidence that a release occurred prior to enrollment.

(c) Failure to provide the agency with a property access agreement from the property owner where the petroleum underground storage tank is located will result in denial of financial assurance funds.

(2) Release from a petroleum underground storage tank prior to enrollment.

(a) The program will provide funds of up to $1,000,000 for remedial action costs to address all releases from a petroleum underground storage tank system that occurred prior to enrollment.

(b) If there is a dispute with the agency determination on timing of the release, the owner or operator must show by clear, cogent, and convincing evidence that a release occurred post enrollment.

(c) Financial assurance funds provided under this subsection will be subject to cost recovery.

(3) Financial assurance coverage shall not exceed $3,000,000 per state fiscal year for multiple occurrences involving a single petroleum underground storage tank.

(4) Priority coverage.

(a) Per RCW 70A.545.020(7), funding for remedial action is prioritized over third-party costs. The agency must reserve the estimated costs of necessary remedial actions, and then payment may be made on eligible third-party costs.

(b) Per RCW 70A.545.020(6), the agency may prioritize program funding for investigations and remedial actions deemed necessary to address:

(i) An emergency which threatens human health or the environment; or

(ii) A population threatened by the release that includes an overburdened community, as defined in RCW 70A.02.010(11), or a vulnerable population, as defined in RCW 70A.02.010(14).

(c) The director may prioritize funding at their discretion using factors specified in guidance.

(5) Once a no further action letter is issued by the agency's technical assistance program for the release from the enrolled petroleum underground storage tank, the financial assurance coverage is complete, and funding will no longer be available.

NEW SECTION

WAC 374-10-070 Financial assurance request. (1) All program participants must review and reference the program policy guidance prior to requesting coverage from the financial assurance program. The agency maintains this document on its website.

(2) An owner or operator of an enrolled petroleum underground storage tank must report a suspected or confirmed release to the department of ecology as required under WAC 173-360A-0700 and 173-360A-0750, or other regulating agency as required by federal law.

(3) To obtain financial assurance funding, a financial assurance request form must be filed with the agency after initial reporting to department of ecology or regulating agency under federal law. An access agreement from the owner of the property where the petroleum underground storage tank is located is required as part of the financial assurance request form.

(4) In a situation where a federal, state, or other regulating agency has responded to the release, this information must be included in the financial assurance request.

(5) The agency will open a financial assurance request case. The agency will conduct a review to determine if the release meets conditions for coverage and whether coverage is for release after enrollment or for release prior to enrollment.

(6) The agency will notify the program participant that the financial assurance request has been accepted and a project manager and site manager have been assigned.

(7) The remedial work conducted will meet the substantive and timing requirements of WAC 173-340-450 Releases from regulated underground storage tank systems or, for releases in Indian country, 40 C.F.R. subtitle 280 Subparts E and F.

(8) Once a no further action letter is issued by the agency's technical assistance program for the release from the enrolled petroleum underground storage tank, the financial assurance request is considered finished and funding will no longer be available.

(9) The owner or operator must accept the schedule and milestones created by the agency to maintain coverage for the release. Failure to accept the schedule and milestones set by the agency may result in cancellation of enrollment and ineligibility of the release to qualify for financial assurance funds.

(10) The owner or operator must provide access for the agency to the property where the enrolled petroleum underground storage tank is located. Failure to provide an access agreement for the property will result in cancellation of enrollment and ineligibility of the release to qualify for financial assurance funds.

(11) To address the release from an enrolled petroleum underground storage tank, the agency may need access and an agreement for the agency to conduct remedial actions on neighboring property not owned by the tank owner or operator. The agency will ask for an access agreement, including an agreement to allow for remedial actions. If access and/or an agreement to allow for remedial actions is denied, the agency will limit remediation to the property where the enrolled petroleum underground storage tank is located. Once that remediation is completed and a no further action letter is issued by the agency's technical assistance program, financial assurance funds will no longer be available.

NEW SECTION

WAC 374-10-080 Eligible third-party claims. (1) A third-party claim relating to a release prior to enrollment from a petroleum underground storage tank will not be eligible for funds under this program. The owner or operator of an enrolled petroleum underground storage tank or a third party have the burden to show the release occurred post enrollment by clear, cogent, and convincing evidence.

(2) For a third-party property claim to be eligible, the following requirements must be met:

(a) If applicable, the third party must consent to property access and sign the access agreement.

(b) If applicable, the third party must allow remediation work to occur on their property.

(c) An agreement that the agency may conduct an audit of any claim honored by the agency and that the third party will reimburse the agency for any disallowance of costs occasioned by such an audit. The third party must also agree to retain all records pertaining to the claim for a period determined by the agency, of at least three years after final payment on the claim, and to provide the records to the agency upon request. The three-year period shall be extended until the completion of any audit in progress.

(3) A financial assurance third-party request form must be submitted before the release receives a no further action letter from the agency's technical assistance program.

(4) After submittal of a financial assurance third-party request form, the agency will send notification of approval or denial of the request.

(a) The third party must report any legal claims against the owner or operator of the enrolled petroleum underground storage tank system when filing for financial assurance coverage. All legal claims for costs and damages resulting from a release from the enrolled petroleum underground storage tank must be completed or settled prior to seeking financial assurance coverage.

(b) The third party shall make available to the agency upon request all documentation of property damage necessary to prove that the property damage is reimbursable. This includes, but is not limited to, pleadings, or any other documents filed in any lawsuit for property damage or bodily injury.

(c) The third party shall make available to the agency upon request documentation of bodily injury to include medical reports, statements, investigative reports, or certifications from licensed health professionals necessary to prove that third-party bodily injuries are reimbursable.

NEW SECTION

WAC 374-10-090 Eligible and ineligible costs. (1) Eligible and ineligible costs are listed in the program guidance.

(2) Eligible costs covered by the financial assurance program include, but are not limited to, the following:

(a) Remedial action performed by an agency prime consultant for releases from a petroleum underground storage tank and its system. Actions may include excavation, treatment and/or removal and proper disposal of any soil or water contaminated by the accidental release, as well as proper disposal of nonrepairable petroleum underground storage tank.

(b) Remedial action costs performed by a consultant under contract to the program participant provided that the remedial action has been approved by PLIA prior to the work being conducted, the costs are in compliance with task-based pricing set by the agency, and the agency determines that the remedial action being conducted by the program participant's consultant will expedite cleanup at the site.

(c) Remedial action which will be compliant with state, federal, or tribal cleanup standards.

(d) Remedial action costs incurred by state, federal, or tribal agencies in responding to the release from the enrolled petroleum underground storage tank.

(e) Testing, monitoring, and assessments.

(f) Third-party costs as defined in WAC 374-10-080.

(g) Necessary infrastructure, petroleum underground storage tank, or petroleum underground storage tank system replacement costs are only considered eligible costs under WAC 374-10-060 (1)(a). Any such replacement must meet the current standards for such tank systems, as specified in program guidance.

(h) Replacement of some surface features required by municipal law, including surface asphalt and concrete, curbs or lanes, and stormwater drainage.

(3) Ineligible costs include, but are not limited to, the following:

(a) Penalties or fines assessed by other local, state, federal, or other regulating agencies.

(b) Third-party cost recovery under MTCA, CERCLA, and lawsuits that is not permitted by WAC 374-10-080 or not an eligible cost reimbursement for a state, federal, or other regulating agency.

(c) Remedial action that exceeds cleanup levels required by MTCA or federal standards.

(d) Lost business income related to the release or remediation.

(e) Cleanup of contamination from other sources, unless the agency determines that it is necessary to complete remediation of a release from an enrolled petroleum underground storage tank.

(f) Legal defense costs, including the costs of legal representation, expert fees, and related costs and expenses incurred in defending against claims or actions brought by or on behalf of:

(i) The United States, Washington state, or a political subdivision of the United States or Washington state to require remedial action or to recover costs of remedial action; or

(ii) A third party for bodily injury or property damage caused by an accidental release.

NEW SECTION

WAC 374-10-100 Agency-led remediation. (1) The owner or operator of a nonenrolled petroleum underground storage tank system, or owner of a property with either a nonenrolled petroleum underground storage tank system or a past release that has been reported to the department of ecology, may submit an agency-led remediation request. An agency-led remediation project will involve the agency conducting remediation related to a release from the petroleum underground storage tank. The agency may seek cost recovery following completion of the remedial actions. This is intended to address properties without viable funding sources to address contamination where the contamination may be impacting drinking water or vulnerable communities.

(2) To qualify for an agency-led remediation request, the owner or operator, or owner of the property, must show the following:

(a) Per RCW 70A.545.060(1)(a), the release occurs in an area of risk for drinking water impacts or where addressing the release is necessary to equitably protect human health and the environment in

communities that have been marginalized, overburdened, and underserved;

(b) The owner or operator, or owner of the property where the petroleum underground storage tank is located, has provided consent for the agency to:

(i) Conduct the remedial actions;

(ii) Enter upon the real property to conduct the remedial actions; and

(iii) Recover the costs of the remedial actions from the owner or operator or potentially liable persons; and

(c) The owner of the property consents to the agency's use of a lien as detailed in RCW 70A.545.070 on the property.

(3) The agency may accept an agency-led remediation request per the director's discretion, subject to program funding availability.

NEW SECTION

WAC 374-10-110 Cost recovery. The agency may recover the costs of remedial actions conducted under the program by use of cost recovery options in the Model Toxics Control Act, RCW 70A.305.080, 70A.545.060, and 70A.545.070, or other applicable federal or state laws.

NEW SECTION

WAC 374-10-120 Overpayments. (1) The agency may require an owner or operator to return any cost overpayment made by the program. Overpayments may occur if:

(a) Another party, such as an insurer, has paid costs prior to payments from the program; or

(b) The agency discovers an accidental overpayment has been made to an owner or operator for any reason.

(2) If a cost overpayment is not paid upon demand, the agency may pursue the following actions:

(a) Collections. The agency may request cost recovery with a debt collection agency.

(b) Lien filing. The agency may seek cost recovery of remedial action costs by filing a lien on the petroleum underground storage tank facility as authorized under RCW 70A.545.070.

(c) Civil action. The agency may request the attorney general office to commence a civil action against the owner or operator in superior court to recover costs and the agency's administrative and legal expenses to pursue recovery.

NEW SECTION

WAC 374-10-130 Fraud and material omissions. (1) The agency may seek return of payments made if:

(a) Any party misrepresents or omits material facts relevant to the agency's determination of coverage; or

(b) Any party, with intent to defraud, initiates a financial assurance request or issues or approves an invoice or request for payment, with knowledge that the information submitted is false in whole or in part.

(2) If the agency determines that any party has committed program fraud or omitted material information relevant to financial assurance program enrollment or payment of remediation costs, the agency may request the attorney general's office to:

(a) File a lien on the petroleum underground storage tank facility or other property owned by the owner or operator to recover the amount of payment that occurred as a result of the fraud or omission;

(b) Commence a civil action against the person in superior court; or

(c) Recover the overpayment costs and other expenses as determined by a court.

(3) If the agency determines that the owner or operator of an enrolled petroleum storage tank omitted material facts or intentionally defrauded the program, it will cancel enrollment of the affected petroleum tank, and any person or party determined to have committed program fraud may be prohibited from applying for future enrollment. The agency will report instances of fraud to the appropriate authorities including criminal referral for prosecution.

(4) Any party participating in the program must agree to allow the agency to conduct financial audits related to the receipt of payments intended for remedial actions and to produce records as requested by the agency.

NEW SECTION

WAC 374-10-140 Review of initial agency decisions. (1) Review of the following initial agency decisions may be requested, in writing, to the agency's legislative and policy manager:

(a) Denial of program eligibility;

(b) Cancellation of enrollment in the program or denial of reenrollment;

(c) Denial of eligibility for payment under the program;

(d) Amount of payment allowed for remedial actions;

(e) Eligibility and amount of payment allowed for a third-party claim;

(f) Agency requests for costs repayment under WAC 374-10-120; or

(g) Other agency program decisions detailed in the program policy guidance.

(2) Review of these initial agency decisions may be requested within 45 days by an applicant, the owner or operator of an enrolled petroleum underground storage tank system, or a third-party claimant.

(3) The written request must specify the basis for review and meet the agency's procedures outlined in the program policy guidance.

(4) If the applicant or participant seeks to appeal the final agency determination, the applicant or participant has 60 days after the agency determination to submit a written request to the director for an adjudicative hearing under chapter 34.05 RCW.

WSR 24-18-052
PERMANENT RULES
DEPARTMENT OF
CHILDREN, YOUTH, AND FAMILIES
[Filed August 28, 2024, 8:57 a.m., effective September 28, 2024]

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

Purpose: The department of children, youth, and families is required to develop a contract and a new type of foster home for professional therapeutic foster care (PTFC) according to the D.S. Settlement Agreement. The intent of the agreement is to remove this barrier in licensing rules and add new language describing eligibility and licensing requirements for professional therapeutic foster parents. In addition, revisions are being made to allow foster care payments to be the sole income of a licensed foster family home. The licensing division must update sections and add new sections to chapter 110-148 WAC to satisfy this legal requirement, as well as to chapters 110-50, 110-80, and 110-145 WAC for definition revisions.

Citation of Rules Affected by this Order: New WAC 110-148-1366, 110-148-1367 and 110-148-1368; and amending WAC 110-50-0420, 110-80-0030, 110-145-1305, 110-148-1305, 110-148-1365, and 110-148-1370.

Statutory Authority for Adoption: RCW 34.05.220, 43.216.020, and 43.216.065.

Adopted under notice filed as WSR 24-15-091 on July 19, 2024.

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

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

Number of Sections Adopted on the Agency's own Initiative: New 3, Amended 6, Repealed 0.

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

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

Date Adopted: August 28, 2024.

Brenda Villarreal
Rules Coordinator

OTS-5625.1

AMENDATORY SECTION (Amending WSR 23-24-040, filed 11/30/23, effective 12/31/23)

WAC 110-50-0420 Definitions for foster care rate assessment (FCRA). The following definitions apply to foster care rate assessments (FCRA):

"Behavior rehabilitation services" or **"BRS"** means a temporary wrap around support and treatment program for youth with extreme, high

level service needs, used to safely stabilize them and assist them in achieving a permanent plan or less intensive service.

"Child placing agency((~~" or "CPA~~)) (CPA)" means an agency or tribe licensed to place children ((~~or youth~~)) for foster care or adoption and may be contracted by the department to provide professional therapeutic foster care services.

"Department" or **"DCYF"** means the department of children, youth, and families.

"Foster care" means the placement of children or youth by DCYF or licensed child placing agencies in homes or facilities licensed or certified pursuant to chapter 74.15 RCW or in homes or facilities that are not required to be licensed pursuant to chapter 74.15 RCW.

"Foster home" or **"foster family home"** means individuals licensed to regularly provide a 24-hour care in their home to children or youth.

"Licensed health care provider" means a medical doctor (MD), doctor of osteopathy (DO), doctor of naturopathy (ND), physician's assistant (PA), or an advanced registered nurse practitioner (ARNP).

"Licensing division" or **"LD"** means the division of the department of children, youth, and families that licenses and monitors foster homes, child placing agencies, and licensed group care facilities under the authority of chapter 74.15 RCW.

"Relatives" means the same as defined in RCW 13.36.020(5), described in RCW 74.15.020(2), or caregivers of Indian children or youth who are defined by tribal code or custom as relatives or extended family.

"Suitable persons" means nonrelatives with whom the child or youth, or the child's or youth's family, has a preexisting relationship; who has completed all required criminal history background checks and otherwise appears to be suitable and competent to provide care for the child or youth, and with whom they have been placed pursuant to RCW 13.34.130.

OTS-5626.1

AMENDATORY SECTION (Amending WSR 20-04-019, filed 1/27/20, effective 2/27/20)

WAC 110-80-0030 What definitions apply to the adoption support program? The following definitions apply to this chapter:

"Adoption" means the granting of an adoption decree consistent with chapter 26.33 RCW.

"Adoption support agreement" means a written contract between the adoptive parents and the department that identifies the specific benefits available to the adoptive parents and other terms and conditions of the agreement.

"Adoption support cash payment" means negotiated monthly cash payments paid pursuant to an adoption support agreement between the adoptive parents and the department.

"Applicant" means a person or couple applying for adoption support on behalf of a child the person or couple plans to adopt.

"Child placing agency (CPA)" means ((~~a private nonprofit~~)) an agency or tribe licensed ((~~by the department under chapter 74.15 RCW~~))

to place children for ((~~adoption or~~)) foster care or adoption and may be contracted by the department to provide professional therapeutic foster care services.

"Department" means the department of children, youth, and families.

"Extenuating circumstances" means a finding by an administrative law judge or a review judge that one or more qualifying conditions or events occurred that erroneously prevented an otherwise eligible child from being placed on the adoption support program prior to adoption.

"Medical services" means services covered by medicaid and administered by the health care authority.

"Negotiation" means the process of working toward an agreement between the department and the adoptive parent on the terms of the adoption support agreement.

"Nonrecurring costs" means reasonable, necessary, and direct expenses related to the cost of finalizing the adoption of a special needs child.

"Placing agency" means the public or private nonprofit agency that has the legal authority to place the child for adoption.

"Program" means the department's adoption support program.

"Reconsideration" means the limited state-funded support that may be available to an eligible child whose adoption was finalized without a valid adoption support agreement in place.

"Resident state" (for purposes of the child's medicaid eligibility) means the state in which the child physically resides. In some cases this may be different from the state of the parent's legal residence.

OTS-5627.1

AMENDATORY SECTION (Amending WSR 22-11-091, filed 5/18/22, effective 6/18/22)

WAC 110-145-1305 What definitions do I need to know to understand this chapter? The following words and terms are for the purpose of this chapter and are important to understand these requirements:

"Abuse or neglect" means the injury, sexual abuse, sexual exploitation, negligent treatment or maltreatment of a child as defined in RCW 26.44.020.

"Adult" means a person 18 years old or older, not in the care of the department.

"Agency" is defined in RCW 74.15.020(1).

"Asexual" means the lack of a sexual attraction or desire for other individuals.

"Assessment" means the appraisal or evaluation of a child's physical, mental, social and emotional condition.

"Bisexual" means individuals who have an emotional or physical attraction to individuals of the same and different genders.

"Business hours" means hours during the day in which state business is commonly conducted. Typically, the hours between 9 a.m. and 5 p.m. on weekdays are considered to be standard hours of operation.

"Capacity" means the age range and maximum number of children on your current license.

"Care provider" means any person who is licensed or authorized to provide care for children and cleared to have unsupervised access to children under the authority of a license.

"Case manager" means a facility employee who coordinates the planning efforts of all the persons working on behalf of a child.

"Case plan" means a written document adhered to and followed by a foster child's parents, foster parents, the department, and all other caregivers. A case plan may include, but is not limited to:

(a) A description of the type of home or facility in which a child is to be placed, including a discussion of the safety and appropriateness of the placement and how the department plans to carry out the voluntary placement agreement entered into or judicial determination made with respect to the child;

(b) A plan for assuring that the child receives safe and proper care and that services are provided to the child, parents or guardians, and foster parents in order to improve the conditions in the parents' home, facilitate returning the child to their own home or the permanent placement of the child, and address the needs of the child while in foster care, including a discussion of the appropriateness of the services that have been provided to the child under the plan;

(c) The health and education records of the child, including the most recent information available regarding:

(i) The names and addresses of the child's health and educational providers;

(ii) The child's grade level performance;

(iii) The child's school records;

(iv) A record of the child's immunizations;

(v) The child's known medical conditions;

(vi) The child's medications; and

(vii) Any other relevant health and education information concerning the child determined to be appropriate by the department;

(d) Relevant professional assessments of the child;

(e) Court orders concerning the child; and

(f) Any other relevant plan, assessment, knowledge, material, or information concerning the child determined to be appropriate by the department.

"Chapter" means chapter 110-145 WAC.

"Child," "children," or "youth" for this chapter, means a person who is one of the following:

(a) Under 18 years old;

(b) Up to 21 years of age and enrolled in services through the department of social and health services developmental disabilities administration (DDA) the day prior to their 18th birthday and pursuing either a high school or equivalency course of study, such as a GED or HSEC, or vocational program;

(c) Up to 21 years of age and participates in the extended foster care program;

(d) Up to 21 years of age with intellectual and developmental disabilities;

(e) Up to 25 years of age and under the custody of juvenile rehabilitation.

"Child placing agency (CPA)" means an agency or tribe licensed to place children for ((~~temporary care, continued care,~~)) foster care or adoption and may be contracted by the department to provide professional therapeutic foster care services.

"Compliance agreement" means a written improvement plan to address the changes needed to meet licensing requirements.

"CW" means the division of child welfare within DCYF. CW provides case management to children and families involved in the child welfare system.

"Day treatment" is a specialized service that provides educational and therapeutic group experiences for emotionally disturbed children.

"DDA" means the developmental disabilities administration in the department of social and health services. DDA provides services and case management to children and adults who meet the eligibility criteria.

"Deescalation" means strategies used to defuse a volatile situation, to assist a child to regain behavior control, and to avoid a physical restraint or other behavioral intervention.

"Department" means the department of children, youth, and families (DCYF).

"Developmental disability" is a disability as defined in RCW 71A.10.020.

"Direct care" means direct, hands-on personal care and supervision to group care children.

"DOH" means the department of health.

"Electronic monitoring" means video or audio monitoring or recording used to watch or listen to children as a way to monitor their behavior.

"Emergency respite center (ERC)" means a licensed facility that may be commonly known as a crisis nursery, which provides emergency or crisis care for nondependent children birth through 17 years for up to 72 hours to prevent child abuse or neglect per RCW 74.15.020(d). ERCs may choose to be open up to 24 hours a day, seven days a week. Facilities may also provide family assessment, family support services, and referrals to community services.

"FBI" means the Federal Bureau of Investigation.

"Full-time" as used throughout this chapter when describing work experience means a minimum of 1,664 work hours in a calendar year or the equivalent of 32 work hours per week.

"Gay" means a sexual orientation to describe individuals who are emotionally or physically attracted to someone of the same gender. Gay is sometimes an umbrella term for the LGBTQIA+ community.

"Gender" or "gender identity" means an individual's inner sense of being a female, male, a blend of both or neither, or another gender. This may or may not correspond with an individual's sex assigned at birth.

"Gender expression" means individuals' outward communication of their gender through behavior or appearance. This may or may not conform to their sex assigned at birth or socially defined behaviors and characteristics typically associated with being either masculine or feminine.

"Gender fluid" means individuals whose gender identities are flexible, not permanent.

"Group care" is a general term for a licensed facility that is maintained and operated for a group of children on a 24-hour basis to provide a safe and healthy living environment that meets the developmental needs of the children in care, per RCW 74.15.020 (1)(f).

"Group home" is a specific license for residential care that provides care and supervision for children.

"Group receiving center" means a licensed facility that provides the basic needs of food, shelter, and supervision for children placed by the department, generally for 30 or fewer days.

"Guardian" has the same meaning in this chapter as defined in RCW 26.33.020(11).

"Guns or weapons" means any device intended to shoot projectiles under pressure or that can be used to attack. These include, but are not limited to, BB guns, pellet guns, air rifles, stun guns, antique guns, handguns, rifles, shotguns, and archery equipment.

"Health care staff" means anyone providing qualified medical consultation to your staff or medical care to the children in your care.

"Hearing" means the administrative review process conducted by an administrative law judge.

"I, my, you, and your" refers to an applicant for a license issued under this chapter, and to any party holding a license under this chapter.

"Infant" means a child less than 12 months of age.

"Intellectual and developmental disability" means children with deficits in general mental abilities and impairment in everyday adaptive functioning.

"Interim facility" means an overnight youth shelter, emergency respite center or a resource and assessment center.

"Intersex" is an umbrella term used to describe a wide range of natural bodily variations when the body is born with a combination of chromosomes, internal organs, or external genitalia that do not develop as expected.

"Lesbian" means females or women who have an emotional or physical attraction for other females or women.

"LGBTQIA+" means lesbian, gay, bisexual, transgender, queer or questioning, intersex, and asexual. The "+" represents identities not specifically named in the LGBTQIA acronym, e.g., pansexual, gender nonbinary, and Two-Spirit.

"License" means a permit issued by us that your facility meets the licensing standards established in this chapter.

"Licensed health care provider" means an MD (medical doctor), DO (doctor of osteopathy), ND (doctor of naturopathy), PA (physician's assistant), or an ARNP (advanced registered nurse practitioner).

"Licensing division (LD)" means the division within DCYF that licenses and monitors foster homes, child placing agencies, and licensed group care facilities.

"Licensing provider portal" means the internet connected provider application system used by the department and agencies to securely store digital employment and licensing documents and data.

"Local fire authority" means your local fire inspection authority having jurisdiction in the area where your facility is located.

"Maternity service" as defined in RCW 74.15.020. These are also referred to as pregnant and parenting youth programs.

"Medically fragile" means the condition of a child who requires the availability of 24-hour skilled care from a health care professional or specially trained staff or volunteers in a group care setting. These conditions may be present all the time or frequently occurring. If the technology, support, and services being received by the medically fragile children are interrupted or denied, the child may, without immediate health care intervention, experience death.

"Missing child" means any child less than 18 years of age in licensed care or under the care, custody, and authority of DCYF and the child's whereabouts are unknown, the child has left care without the permission of the child's caregiver or DCYF, or both. This does not include children in a dependency guardianship.

"Multidisciplinary teams (MDT)" means groups formed to assist children who are considered at-risk children in need of services, and their parents.

"Negative action" means a court order, court judgment, or adverse action taken by an agency, in any state, federal, local, tribal, or foreign jurisdiction, that results in a finding against the applicant reasonably related to the individual's suitability, and competence to care for or have unsupervised access to children in out-of-home care. This may include, but is not limited to:

(a) A decision issued by an administrative law judge;

(b) A final determination, decision, or finding made by an agency following an investigation;

(c) An adverse licensing action, including termination, revocation, or denial of a license or certification, or if there is a pending adverse action, the voluntary surrender of a license, certification, or contract in lieu of an adverse action;

(d) A revocation, denial, or restriction placed on any professional license; or

(e) A final decision of a disciplinary board.

"Nonambulatory" means not able to walk or exit to safety without the physical assistance of another individual.

"Nonbinary" is a term of self-identification for individuals who do not identify within the limited and binary terms that have described gender identity, e.g., female and male. Nonbinary is also an umbrella term for many identities such as gender expansive, gender fluid, and genderqueer.

"Out-of-home placement" means a child's placement in a home or facility other than the child's parent, guardian, or legal custodian.

"Overnight youth shelter" means a licensed nonprofit agency that provides overnight shelter to homeless or runaway youth in need of emergency sleeping arrangements.

"Parent" has the same meaning in this chapter as defined in RCW 26.26A.010(15).

"Probationary license" means a license issued as part of a corrective action to an individual or agency that has previously been issued a full license but is out of compliance with minimum licensing requirements and has entered into an agreement aimed at correcting deficiencies.

"Property or premises" means a facility's buildings and adjoining grounds that are managed by a person or agency in charge.

"Psychotropic medication" means a type of medicine that is prescribed to affect or alter thought processes, mood, sleep, or behavior. These include antipsychotic, antidepressant, and antianxiety medications.

"Queer" is a term used to express LGBTQIA+ identities and orientations. The term is sometimes used as an umbrella term for all LGBTQIA+ individuals.

"Questioning" means individuals who are exploring their sexual orientation, gender identity, or gender expression at any age.

"Relative" means a person who is related to a child under RCW 74.15.020.

"Resource and assessment center" means an agency that provides short-term emergency and crisis care for a period up to 72 hours, (excluding Saturdays, Sundays, and holidays) to children who have been removed from their parent's or guardian's care by child protective services or law enforcement.

"Secure crisis residential center" means a licensed facility open 24 hours a day, seven days a week that provides temporary residential placement, assessment and services in a secure facility to prevent youth from leaving the facility without permission, per RCW 13.32A.030(15).

"Semi-secure crisis residential center" means a licensed facility open 24 hours a day, seven days a week that provides temporary residential placement, assessment and services for runaway youth and youth in conflict with their family or in need of emergency placement.

"Sexual orientation" means an individual's emotional or physical attraction to other individuals.

"SOGIE" is an acronym for sexual orientation, gender identity, and expression which are distinct identifiers everyone has. LGBTQIA+ is a subdistinction within SOGIE self-identifiers. SOGIE includes LGBTQIA+ as well as heterosexual, cisgender, and nonquestioning individuals.

"Staff" or "staff member" means a person who provides services for your facility and is paid by your facility. The definition of staff member includes paid interns.

"Staffed residential home" means a licensed facility that provides 24-hour care to six or fewer children who require more supervision than can be provided in a foster home.

"Transgender" is an umbrella term for individuals whose gender identity or expression is different from cultural expectations based on the sex they were assigned at birth. Gender-affirming medical care is not a prerequisite to identify as transgender. Being transgender does not imply any specific sexual orientation.

"Treatment plan" means individual plans that identify the service needs of the child, including the child's parent or guardian, and identifies the treatment goals and strategies for achieving those goals.

"Two-Spirit" means a modern, pan-indigenous, umbrella term used by some indigenous North Americans to describe Native people in their communities who fulfill a traditional third-gender or other gender-variant, ceremonial, and social role in their cultures. Being Two-Spirit does not imply any specific sexual orientation.

"Volunteer" means a person who provides services for your facility without compensation.

"Washington state patrol fire protection bureau (WSP/FPB)" means the state fire marshal.

"We, our, and us" refers to DCYF and its staff.

"Young child" refers to a child age 12 months through eight years old.

OTS-5628.2

AMENDATORY SECTION (Amending WSR 22-11-091, filed 5/18/22, effective 6/18/22)

WAC 110-148-1305 What definitions do I need to know to understand this chapter? The following definitions are for the purpose of this chapter and are important to understanding these requirements:

"Abuse or neglect" means the injury, sexual abuse, sexual exploitation, negligent treatment or maltreatment of a child as defined in RCW 26.44.020.

"Adult" means a person 18 years of age and older, not in the care of the department.

"Agency" is defined in RCW 74.15.020(1).

"Asexual" means the lack of a sexual attraction or desire for other individuals.

"Bisexual" means individuals who have an emotional or physical attraction to individuals of the same and different genders.

"Capacity" means the age range and maximum number of children on your current license.

"Care provider" means any person who is licensed or authorized to provide care for children, and cleared to have unsupervised access to children under the authority of a license.

"Case manager" means the private agency employee who coordinates the planning efforts of all the persons working on behalf of a child.

"Case plan" means a written document adhered to and followed by a foster child's parent or parents, foster parent or parents, the department, and all other caregivers. A case plan may include, but is not limited to:

(a) A description of the type of home or facility in which a child is to be placed, including a discussion of the safety and appropriateness of the placement and how the department plans to carry out the voluntary placement agreement entered into or judicial determination made with respect to the child;

(b) A plan for assuring that the child receives safe and proper care and that services are provided to the parents, child, and foster parents in order to improve the conditions in the parents' home, facilitate return of the child to their own safe home or the permanent placement of the child, and address the needs of the child while in foster care, including a discussion of the appropriateness of the services that have been provided to the child under the plan;

(c) The health and education records of the child, including the most recent information available regarding:

(i) The names and addresses of the child's health and educational providers;

(ii) The child's grade level performance;

(iii) The child's school record;

(iv) A record of the child's immunizations;

(v) The child's known medical conditions;

(vi) The child's medications; and

(vii) Any other relevant health and education information concerning the child determined to be appropriate by the department;

(d) Relevant professional assessments of the child;

(e) Court orders concerning the child; and

(f) Any other relevant plan, assessment, knowledge, material, or information concerning the child determined to be appropriate by the department.

"Caseworker" means the primary agency worker assigned to the child through DCYF or another government agency.

"Certification" means either:

(a) Our review of whether you meet the licensing requirements, even though you do not need to be licensed; or

(b) A licensed child placing agency (CPA) representing that a foster home being supervised by that CPA meets licensing requirements. The final decision for licensing is the responsibility of DCYF.

"Chapter" means chapter 110-148 WAC.

"Child," "children," or "youth" for this chapter, means a person who is one of the following:

(a) Under 18 years of age;

(b) Up to 21 years of age and enrolled in services through department of social and health services, developmental disabilities administration (DDA) the day prior to his or her 18th birthday and pursuing either a high school or equivalency course of study (GED/HSEC), or vocational program;

(c) Up to 21 years of age and participates in the extended foster care program;

(d) Up to 21 years of age with intellectual and developmental disabilities;

(e) Up to 25 years of age and under the custody of juvenile rehabilitation.

"Child placing agency (CPA)" means an agency or tribe licensed to place children for foster care or adoption and may be contracted by the department to provide professional therapeutic foster care (PTFC) services.

"Child welfare" or "CW" means the division of child welfare within DCYF. CW provides case management to children and families involved in the child welfare system.

"Compliance agreement" means a written improvement plan to address the changes needed to meet licensing requirements.

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

"Department((~~" or "DCYF" means the department~~)) of children, youth, and families (DCYF)" or "department" means the Washington state department of children, youth, and families.

"Developmental disability" is a disability as defined in RCW 71A.10.020.

"FBI" means the Federal Bureau of Investigation.

"Foster home or foster family home" means a person(s) licensed to regularly provide 24-hour care in their home to children.

"Gay" means a sexual orientation to describe individuals who are emotionally or physically attracted to someone of the same gender. Gay is sometimes an umbrella term for the LGBTQIA+ community.

"Gender" or "gender identity" means an individual's inner sense of being a female, male, a blend of both or neither, or another gender. This may or may not correspond with an individual's sex assigned at birth.

"Gender expression" means individuals' outward communication of their gender through behavior or appearance. This may or may not conform to their sex assigned at birth or socially defined behaviors and characteristics typically associated with being either masculine or feminine.

"Gender fluid" means individuals whose gender identities are flexible, not permanent.

"Guardian" has the same meaning in this chapter as defined in RCW 26.33.020(11).

"Guns or weapons" means any device intended to shoot projectiles under pressure or that can be used to attack. These include but are not limited to BB guns, pellet guns, air rifles, stun guns, antique guns, handguns, rifles, shotguns and archery equipment.

"Hearing" means the administrative review process conducted by an administrative law judge.

"I, my, you, and your" refers to an applicant for a license issued under this chapter, and to any party holding a license under this chapter.

"Infant" means a child less than 12 months of age.

"Intellectual and developmental disability" means children with deficits in general mental abilities and impairment in everyday adaptive functioning.

"Intersex" is an umbrella term used to describe a wide range of natural bodily variations when the body is born with a combination of chromosomes, internal organs, or external genitalia that do not develop as expected.

"Lesbian" means females or women who have an emotional or physical attraction for other females or women.

"LGBTQIA+" means lesbian, gay, bisexual, transgender, queer or questioning, intersex, and asexual. The "+" represents identities not specifically named in the LGBTQIA acronym, e.g., pansexual, gender nonbinary, and Two-Spirit.

"License" means a permit issued by us confirming that you and your home meet the licensing standards established in this chapter.

"Licensed health care provider" means a medical doctor (MD), doctor of osteopathy (DO), doctor of naturopathy (ND), physician's assistant (PA), or an advanced registered nurse practitioner (ARNP).

"Licensing division (LD)" means the division within DCYF that licenses and monitors foster homes, child placing agencies, and licensed group care facilities.

"Licensor" means either:

(a) A LD employee who recommends approvals for, or monitors licenses or certifications for facilities and agencies established under this chapter; or

(b) An employee of a CPA who certifies or monitors foster homes supervised by the CPA.

"Maternity services" as defined in RCW 74.15.020. These are also referred to as pregnant and parenting youth programs.

"Medically fragile" means the condition of a child who requires the availability of 24-hour skilled care from a health care professional or specially trained family or foster family member. These conditions may be present all the time or frequently occurring. If the technology, support, and services being received by the medically fragile children are interrupted or denied, the child may, without immediate health care intervention, experience death.

"Missing child" means any child less than 18 years of age in licensed care or under the care, custody, and authority of DCYF and the child's whereabouts are unknown or the child has left care without the permission of the child's caregiver or DCYF. This does not include children in dependency guardianship.

"Nonambulatory" means not able to walk or exit to safety without the physical assistance of another individual.

"Nonbinary" is a term of self-identification for individuals who do not identify within the limited and binary terms that have described gender identity, e.g., female and male. Nonbinary is also an umbrella term for many identities such as gender expansive, gender fluid, and genderqueer.

"Out-of-home placement" means a child's placement in a home or facility other than the home of a child's parent, guardian, or legal custodian.

"Parent" has the same meaning in this chapter as defined in RCW 26.26A.010(15).

"Probationary license" means a license issued as part of a corrective action to an individual or agency that has previously been issued a full license but is out of compliance with minimum licensing requirements and has entered into an agreement aimed at correcting deficiencies.

"Professional therapeutic foster care (PTFC)" means a foster home that is certified by a CPA to provide PTFC services.

"Property or premises" means your buildings and grounds adjacent to your residential property that are owned or managed by you.

"Psychotropic medication" means a type of medicine prescribed to affect or alter thought processes, mood, sleep, or behavior. These include anti-psychotic, anti-depressant, and anti-anxiety medications.

"Queer" is a term used to express LGBTQIA+ identities and orientations. The term is sometimes used as an umbrella term for all LGBTQIA+ individuals.

"Questioning" means individuals who are exploring their sexual orientation, gender identity, or gender expression at any age.

"Relative" means a person who is related to a child as defined in RCW 74.15.020.

"Respite" means brief, temporary relief care provided by an in-home or out-of-home provider paid by the department. The respite provider fulfills some or all of the care provider responsibilities for a short time.

"Sexual orientation" means an individual's emotional or physical attraction to other individuals.

"SOGIE" is an acronym for sexual orientation, gender identity, and expression which are distinct identifiers everyone has. LGBTQIA+ is a subdistinction within SOGIE self-identifiers. SOGIE includes LGBTQIA+ as well as heterosexual, cisgender, and nonquestioning individuals.

"Transgender" is an umbrella term for individuals whose gender identity or expression is different from cultural expectations based on the sex they were assigned at birth. Gender-affirming medical care is not a prerequisite to identify as transgender. Being transgender does not imply any specific sexual orientation.

"Treatment plan" means individual plans that identify the service needs of the child, including the child's parent or guardian, and identifies the treatment goals and strategies for achieving those goals.

"Two-Spirit" means a modern, pan-indigenous umbrella term used by some indigenous North Americans to describe Native people in their communities who fulfill a traditional third-gender or other gender-variant, ceremonial, and social role in their cultures. Being Two-Spirit does not imply any specific sexual orientation.

"Washington state patrol fire protection bureau or WSP/FPB" means the state fire marshal.

"We, our, and us" refers to the department of children, youth, and families, including LD and CW staff.

"Young child" refers to a child age 12 months through eight years old.

AMENDATORY SECTION (Amending WSR 22-11-091, filed 5/18/22, effective 6/18/22)

WAC 110-148-1365 What are the personal requirements for foster parents? (1) You must be at least 21 years old to apply for a license.

(2) You must demonstrate you have:

(a) The understanding, ability, physical health, emotional stability, and personality suited to meet the physical, mental, emotional, cultural, and social needs of children under your care;

(b) Sufficient regular income to maintain your own family, without ((~~the~~)) foster care reimbursement ((~~made for the children in your care~~)) unless you are an approved PTFC home as outlined in WAC 110-148-1366; and

(c) ((~~To be able~~)) The ability to communicate with the child, the department, health care providers, and other service providers.

(3) You must ((~~adhere to, follow, and~~)) comply with the case plan for the children in your care.

(4) You ((~~may~~)) must not use drugs or alcohol, whether legal or illegal, in a manner that affects your ability to provide safe care to children.

(5) You and everyone residing on your premises or who you allow to have unsupervised access to children must demonstrate they ((~~have the ability to furnish~~)) can provide children with a nurturing, respectful, and supportive environment.

NEW SECTION

WAC 110-148-1366 What are the qualifications to provide PTFC services? (1) You must be a licensed foster parent through a CPA; and

(2) You must meet the requirements specified in the PTFC contract.

NEW SECTION

WAC 110-148-1367 What happens if I am applying to provide PTFC services and I do not have sufficient income? The department may issue you a license if you meet all other PTFC requirements but lack sufficient income to provide general foster care.

NEW SECTION

WAC 110-148-1368 What happens if I stop providing PTFC services? If you are approved as a PTFC home and stop providing PTFC services within the contracted time frame:

(1) You must inform the CPA and the department; and

(2) The department must:

(a) Place you in no referral status; and

(b) Not place any additional children in the home until you provide income verification that meets the requirements for general foster care in WAC 110-148-1365 (2)(b).

AMENDATORY SECTION (Amending WSR 18-14-078, filed 6/29/18, effective 7/1/18)

WAC 110-148-1370 What kinds of assessments are included in the licensing process? (1) The department or ((~~child placing agency~~)) CPA will assess you for a foster family license. This will include, but is not ((~~necessarily~~)) limited to:

(a) Your ability to comply with the licensing requirements;

(b) The physical condition of your home and property;

(c) The physical and mental health of all members of the household; and

(d) Your ability to provide sufficient income to meet the financial needs of your family without the foster care reimbursements for foster children in your care, unless you are an approved PTFC home.

(2) At any time, we may require:

(a) You or someone in your house to give additional information((~~. We may also require~~)); or

(b) An evaluation of your home or property, or of a person in your home, by an evaluator((~~/~~)) or provider approved by the department.

(3) ((~~Any~~)) Evaluations requested by the department will be at your expense.

(4) You must give the evaluator written permission to share information with us throughout the evaluation process.

WSR 24-18-059
PERMANENT RULES
HEALTH CARE AUTHORITY
[Filed August 28, 2024, 11:25 a.m., effective September 28, 2024]

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

Purpose: The health care authority amended this rule to extend the expiration date for the ambulance transport fund from July 1, 2024, to July 1, 2028, to align with RCW 74.70.901 (SB 5122, chapter 11, Laws of 2023).

Citation of Rules Affected by this Order: Amending WAC 182-546-4700.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Other Authority: RCW 74.70.901 (SB 5122, chapter 11, Laws of 2023).

Adopted under notice filed as WSR 24-15-070 on July 17, 2024.

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

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

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

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

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

Date Adopted: August 28, 2024.

Wendy Barcus
Rules Coordinator

OTS-5555.1

AMENDATORY SECTION (Amending WSR 21-15-010, filed 7/8/21, effective 8/8/21)

WAC 182-546-4700 Ambulance transportation—Ambulance transport fund—Purpose. Chapter 74.70 RCW establishes the quality assurance fee for specified providers of emergency ambulance services through July 1, ((~~2024~~)) 2028. The fee is added to base funding from all other sources to support additional medicaid payments. The fee applies to nonpublic and nonfederal providers of emergency ambulance services. This is a dedicated fund established within the state treasury, known as the ambulance transport fund. The ambulance transport fund is used to receive and distribute funds.

WSR 24-18-060
PERMANENT RULES
HEALTH CARE AUTHORITY
[Filed August 28, 2024, 11:38 a.m., effective September 28, 2024]

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

Purpose: The health care authority amended these rules to reduce the sole community hospital rate multiplier to 1.25, effective July 1, 2024.

Citation of Rules Affected by this Order: Amending WAC 182-550-3830 and 182-550-7550.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Adopted under notice filed as WSR 24-15-073 on July 18, 2024.

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

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

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

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

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

Date Adopted: August 28, 2024.

Wendy Barcus
Rules Coordinator

OTS-5556.1

AMENDATORY SECTION (Amending WSR 23-20-048, filed 9/28/23, effective 10/29/23)

WAC 182-550-3830 Adjustments to inpatient rates. (1) The medicaid agency updates all of the following components of a hospital's specific diagnosis-related group (DRG) factor and per diem rates at rebase:

(a) Wage index adjustment;

(b) Direct graduate medical education (DGME); and

(c) Indirect medical education (IME).

(2) Effective January 1, 2015, the agency updates the sole community hospital adjustment.

(3) The agency does not update the statewide average DRG factor between rebasing periods, except:

(a) To satisfy the budget neutrality conditions in WAC 182-550-3850; and

(b) When directed by the legislature.

(4) The agency updates the wage index to reflect current labor costs in the core-based statistical area (CBSA) where a hospital is located. The agency:

(a) Determines the labor portion by multiplying the base factor or rate by the labor factor established by medicare; then

(b) Multiplies the amount in (a) of this subsection by the most recent wage index information published by the Centers for Medicare and Medicaid Services (CMS) when the rates are set; then

(c) Adds the nonlabor portion of the base rate to the amount in (b) of this subsection to produce a hospital-specific wage adjusted factor.

(5) DGME. The agency obtains DGME information from the hospital's most recently filed medicare cost report that is available in the CMS health care cost report information system (HCRIS) dataset.

(a) The hospital's medicare cost report must cover a period of 12 consecutive months in its medicare cost report year.

(b) If a hospital's medicare cost report is not available on HCRIS, the agency may use the CMS Form 2552-10 to calculate DGME.

(c) If a hospital has not submitted a CMS medicare cost report in more than 18 months from the end of the hospital's cost reporting period, the agency considers the current DGME costs to be zero.

(d) The agency calculates the hospital-specific DGME by dividing the DGME cost reported on worksheet B, part 1 of the CMS cost report by the adjusted total costs from the CMS cost report.

(6) IME. The agency sets the IME adjustment equal to the "IME adjustment factor for Operating PPS" available in the most recent CMS final rule impact file on CMS's website as of May 1st of the rate-setting year.

(7) Sole community hospitals.

(a) For sole community hospitals' rate enhancements, the agency multiplies an in-state hospital's specific conversion factor and per diem rates by a multiplier if the hospital meets all the following criteria per RCW 74.09.5225:

(i) Be certified by CMS as a sole community hospital as of January 1, 2013;

(ii) Have a level III adult trauma service designation from the Washington state department of health (DOH) as of January 1, 2014;

(iii) Have less than 150 acute care licensed beds in fiscal year 2011;

(iv) Be owned and operated by the state or a political subdivision; and

(v) Not participate in the certified public expenditures (CPE) payment program defined in WAC 182-550-4650.

(b) ((~~As of July 1, 2021, through June 30, 2023, an additional increase is applied for hospitals that accept single bed certifications per RCW 71.05.745.~~)) Effective July 1, 2024, the enhancement multiplier equals 1.25. This may be adjusted in future years to account for legislatively approved increases. (See RCW 74.09.5225)

Enhancement Multiplier by Year							
	Effective For the Dates						
Provider Category	07/01/2015 - 06/30/2020	07/01/2020 - 06/30/2021	07/01/2021 - 06/30/2022	07/01/2022 - 06/30/2023	07/01/2023 - 12/31/2023	01/01/2024 - 06/30/2024	07/01/2024
Sole community hospital	1.25	1.5	((~~N/A~~)) 1.5	1.25	1.25	1.5	1.25
Sole community hospital accepting single bed certifications	N/A	N/A	1.5	1.5	N/A	N/A	N/A

AMENDATORY SECTION (Amending WSR 23-20-048, filed 9/28/23, effective 10/29/23)

WAC 182-550-7550 OPPS payment enhancements. (1) Pediatric adjustment.

(a) The medicaid agency establishes a policy adjustor to be applied to all enhanced ambulatory patient group (EAPG) services for clients under age 18 years.

(b) Effective July 1, 2014, this adjustor equals one point thirty-five (1.35).

(2) Chemotherapy and combined chemotherapy/pharmacotherapy adjustment.

(a) The agency establishes a policy adjustor to be applied to services grouped as chemotherapy drugs or combined chemotherapy and pharmacotherapy drugs.

(b) Effective July 1, 2014, this adjustor equals one point one (1.1).

(3) Sole community hospitals.

(a) For sole community hospital's rate enhancements, the agency multiplies the in-state hospital's specific EAPG conversion factor by a multiplier if the hospital meets all of the following criteria per RCW 74.09.5225:

(i) Be certified by CMS as a sole community hospital as of January 1, 2013;

(ii) Have a level III adult trauma service designation from the Washington state department of health (DOH) as of January 1, 2014;

(iii) Have less than 150 acute care licensed beds in fiscal year 2011; and

(iv) Be owned and operated by the state or a political subdivisions.

(b) ((~~As of July 1, 2021, through June 30, 2023, an additional increase may be applied for hospitals that accept single bed certifications per RCW 71.05.745.~~)) Effective July 1, 2024, the enhancement multiplier equals 1.25. This may be adjusted in future years to account for legislatively approved increases. (See RCW 74.09.5225)

Enhancement Multiplier by Year							
	Effective For the Dates						
Provider Category	07/01/2015 - 06/30/2020	07/01/2020 - 06/30/2021	07/01/2021 - 06/30/2022	07/01/2022 - 06/30/2023	07/01/2023 - 12/31/2023	01/01/2024 - 06/30/2024	07/01/2024
Sole community hospital	1.25	1.5	((~~N/A~~)) 1.5	1.25	1.25	1.50	1.25
Sole community hospital accepting single bed certifications	N/A	N/A	1.5	1.5	N/A	N/A	N/A

WSR 24-18-061
PERMANENT RULES
HEALTH CARE AUTHORITY
[Filed August 28, 2024, 12:27 p.m., effective September 28, 2024]

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

Purpose: The health care authority amended this rule to add gender affirming surgery services to being exempt from diagnosis-related group payment.

Citation of Rules Affected by this Order: Amending WAC 182-550-4400.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Adopted under notice filed as WSR 24-15-074 on July 18, 2024.

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

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

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

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

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

Date Adopted: August 28, 2024.

Wendy Barcus
Rules Coordinator

OTS-5557.1

AMENDATORY SECTION (Amending WSR 23-08-085, filed 4/5/23, effective 5/6/23)

WAC 182-550-4400 Services—Exempt from DRG payment. (1) Inpatient services are exempt from the diagnosis-related group (DRG) payment method only if they qualify for payment methods specifically mentioned in other sections of this chapter or in this section.

(2) Subject to the restrictions and limitations in this section, the agency exempts the following services for medicaid and CHIP clients from the DRG payment method. This policy also applies to covered services paid through medical care services (MCS) and any other state-administered program, except when otherwise indicated in this section. The exempt services are:

(a) Withdrawal management services when provided in a hospital having a withdrawal management provider agreement with the agency to perform these services.

(b) Hospital-based intensive inpatient withdrawal management, medical stabilization, and drug treatment services provided to substance-using pregnant people (SUPP) clients by an agency-approved hospital. These are medicaid program services and are not covered or funded by the agency through MCS or any other state-administered program.

(c) Acute physical medicine and rehabilitation (acute PM&R) services.

(d) Psychiatric services. An agency designee that arranges to pay a hospital directly for psychiatric services may use the agency's payment methods or contract with the hospital to pay using different methods.

(e) Chronic pain management treatment provided in a hospital approved by the agency to provide that service.

(f) Administrative day services. The agency pays administrative days for one or more days of a hospital stay in which an acute inpatient or observation level of care is not medically necessary, and a lower level of care is appropriate. The administrative day rate is based on the statewide average daily medicaid nursing facility rate, which is adjusted annually. The agency may designate part of a client's stay to be paid an administrative day rate upon review of the claim or the client's medical record, or both.

(g) Inpatient services recorded on a claim grouped by the agency to a DRG for which the agency has not published an all-patient DRG (AP-DRG) or all-patient refined DRG (APR-DRG) relative weight. The agency will deny payment for claims grouped to APR DRG 955 or APR DRG 956.

(h) Organ transplants that involve heart, intestine, kidney, liver, lung, allogeneic bone marrow, autologous bone marrow, pancreas, or simultaneous kidney/pancreas. The agency pays hospitals for these organ transplants using the ratio of costs-to-charges (RCC) payment method. The agency maintains a list of DRGs which qualify as transplants on the agency's website.

(i) Gender affirming surgery.

WSR 24-18-062
PERMANENT RULES
HEALTH CARE AUTHORITY
[Filed August 28, 2024, 1:59 p.m., effective September 30, 2024]

Effective Date of Rule: September 30, 2024.

Purpose: The health care authority is amending WAC 182-512-0600, 182-512-0650, and 182-512-0800 to remove food assistance from the calculation of income when determining a person's eligibility for Washington apple health supplemental security income (SSI)-related medical programs.

Citation of Rules Affected by this Order: Amending WAC 182-512-0600, 182-512-0650, and 182-512-0800.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Other Authority: 20 C.F.R. Part 416, Subpart K.

Adopted under notice filed as WSR 24-15-098 on July 22, 2024.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 3, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

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

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

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 3, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 3, Repealed 0.

Date Adopted: August 28, 2024.

Wendy Barcus
Rules Coordinator

OTS-5566.1

AMENDATORY SECTION (Amending WSR 19-11-050, filed 5/10/19, effective 6/10/19)

WAC 182-512-0600 SSI-related medical—Definition of income. (1) Income is anything a client receives in cash or in-kind that can be used to meet ((~~his/her~~)) the client's needs for ((~~food or~~)) shelter. Income can be earned or unearned.

(2) Some receipts are not income because they do not meet the definition of income above. Some types of receipts that are not income are:

(a) Cash or in-kind assistance from federal, state, or local government programs whose purpose is to provide medical care or services;

(b) Some in-kind payments that are not ((~~food or~~)) shelter coming from nongovernmental programs whose purposes are to provide medical care or medical services;

(c) Payments for repair or replacement of an exempt resource;

(d) Refunds or rebates for money already paid;

(e) Receipts from sale of a resource;

(f) Replacement of income already received (see 20 C.F.R. 416.1103 for a more complete list of receipts that are not income); and

(g) Receipts from extraction of exempt resources for a member of a federally recognized tribe.

(3) Earned income includes the following types of payments:

(a) Gross wages and salaries, including garnished amounts;

(b) Commissions and bonuses;

(c) Severance pay;

(d) Other special payments received because of employment;

(e) Net earnings from self-employment (WAC 182-512-0840 describes earnings exclusions);

(f) Self-employment income of tribal members unless the income is specifically exempted by treaty;

(g) Payments for services performed in a sheltered workshop or work activities center;

(h) Royalties earned by a client in connection with any publication of their work and any honoraria received for services rendered; and

(i) In-kind payments made in lieu of cash wages, including the value of ((~~food or~~)) shelter.

(4) Unearned income is all income that is not earned income. Some types of unearned income are:

(a) Annuities, pensions, and other periodic payments;

(b) Alimony and support payments;

(c) Voluntary or court-ordered child support payments, including arrears, received from a noncustodial parent for the benefit of a child are the income of the child;

(d) Dividends and interest;

(e) Royalties (except for royalties earned by a client in connection with any publication of their work and any honoraria received for services rendered which would be earned income);

(f) Capital gains;

(g) Rents;

(h) Benefits received as the result of another's death to the extent that the total amount exceeds the expenses of the deceased person's last illness and burial paid by the recipient;

(i) Gifts;

(j) Inheritances;

(k) Prizes and awards; and

(l) Amounts received by tribal members from gaming revenues with the exceptions cited in WAC 182-512-0770(3).

(5) Some items which may be withheld from income, but which the agency considers as received income are:

(a) Federal, state, or local income taxes;

(b) Health or life insurance premiums;

(c) SMI premiums;

(d) Union dues;

(e) Penalty deductions for failure to report changes;

(f) Loan payments;

(g) Garnishments;

(h) Child support payments, court ordered or voluntary (WAC 182-512-0900 has an exception for deemors);

(i) Service fees charged on interest-bearing checking accounts;

(j) Inheritance taxes; and

(k) Guardianship fees if presence of a guardian is not a requirement for receiving the income.

(6) Countable income, for the purposes of this chapter, means all income that is available to the client:

(a) If it cannot be excluded; and

(b) After deducting all allowable disregards and deductions.

AMENDATORY SECTION (Amending WSR 14-07-059, filed 3/14/14, effective 4/14/14)

WAC 182-512-0650 SSI-related medical—Available income. (1) Income is considered available to a person at the earliest of when it is:

(a) Received; or

(b) Credited to a person's account; or

(c) Set aside for ((~~his or her~~)) the person's use; or

(d) Used or can be used to meet the person's needs for ((~~food or~~)) shelter.

(2) Anticipated nonrecurring lump sum payments are treated as income in the month received, with the exception of those listed in WAC 182-512-0700(5), and any remainder is considered a resource in the following month.

(3) Reoccurring income is considered available in the month of normal receipt, even if the financial institution posts it before or after the month of normal receipt.

(4) In-kind income received from anyone other than a legally responsible relative is considered available income only if it is earned income.

AMENDATORY SECTION (Amending WSR 21-08-085, filed 4/7/21, effective 5/8/21)

WAC 182-512-0800 SSI-related medical—General income exclusions. The agency excludes, or does not consider, the following when determining a person's eligibility for Washington apple health SSI-related medical programs:

(1) The first ((~~twenty dollars~~)) $20 per month of unearned income. If there is less than ((~~twenty dollars~~)) $20 of unearned income in a month, the remainder is excluded from earned income in that month.

(a) The ((~~twenty-dollar~~)) $20 limit is the same, whether applying it for a couple or for a single person.

(b) The disregard does not apply to income paid totally or partially by the federal government or a nongovernmental agency on the basis of an eligible person's needs.

(c) The ((~~twenty dollars~~)) $20 disregard is applied after all exclusions have been taken from income.

(2) Income that is not reasonably anticipated or is received infrequently or irregularly, whether for a single person or each person in a couple when it is:

(a) Earned and does not exceed a total of ((~~thirty dollars~~)) $30 per calendar quarter; or

(b) Unearned and does not exceed a total of ((~~sixty dollars~~)) $60 per calendar quarter;

(c) An increase in a person's burial funds that were established on or after November 1, 1982, if the increase is the result of:

(i) Interest earned on excluded burial funds; or

(ii) Appreciation in the value of an excluded burial arrangement that was left to accumulate and become part of separately identified burial funds.

(3) Essential expenses necessary for a person to receive compensation (e.g., necessary legal fees in order to get a settlement).

(4) Receipts, which are not considered income, when they are for:

(a) Replacement or repair of an exempt resource;

(b) Prepayment or repayment of medical care paid by a health insurance policy or medical service program; or

(c) Payments made under a credit life or credit disability policy.

(5) The fee a guardian or representative payee charges as reimbursement for providing services, when such services are a requirement for the person to receive payment of the income.

(6) Funds representing shared household costs.

(7) Crime victim's compensation.

(8) The value of a common transportation ticket, given as a gift, that is used for transportation and not converted to cash.

(9) Gifts that are not for ((~~food,~~)) clothing or shelter((~~, and gifts of home produce used for personal consumption~~)).

(10) In-kind payments. The agency does not consider in-kind income received from someone other than a person legally responsible for the person unless it is earned. Therefore, the following in-kind payments are not counted when determining eligibility for apple health SSI-related medical programs:

(a) In-kind payments for services paid by a person's employer if:

(i) The service is not provided in the course of an employer's trade or business; or

(ii) The service is in the form of food that is on the employer's business premises and for the employer's convenience; or

(iii) The service is in the form of shelter that is on the employer's business premises, for the employer's convenience, and required to be accepted by the employee as a condition of employment.

(b) In-kind payments made to people in the following categories:

(i) Agricultural employees;

(ii) Domestic employees;

(iii) Members of the uniformed services; and

(iv) Persons who work from home to produce specific products for the employer from materials supplied by the employer.

(11) Unearned income withheld, before receipt by the person, for mandatory income tax purposes.

WSR 24-18-066
PERMANENT RULES
OFFICE OF
FINANCIAL MANAGEMENT
[Filed August 29, 2024, 10:42 a.m., effective October 1, 2024]

Effective Date of Rule: October 1, 2024.

Purpose: To align WAC 357-25-027 with the requirements in ESHB 1795, chapter 133, Laws of 2022. ESHB 1795 passed during the 2022 legislative session with an effective date of June 9, 2022. This bill prohibits nondisclosure and nondisparagement provisions from employers regarding illegal acts of discrimination, harassment, retaliation, wage and hour violations, and sexual assault. This bill repeals RCW 49.44.210 and replaces it with RCW 49.44.211. The amendments to WAC 357-25-027 repeal subsection (17) to replace it with updated language and amend the "employee" definition reference from RCW 49.44.210 to RCW 49.44.211 to align with the changes in law.

Citation of Rules Affected by this Order: Amending WAC 357-25-027.

Statutory Authority for Adoption: RCW 41.06.150.

Other Authority: RCW 49.44.211.

Adopted under notice filed as WSR 24-14-105 on July 1, 2024.

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

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

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

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 1, Amended 3, Repealed 0.

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

Date Adopted: August 29, 2024.

Nathan Sherrard
Legal Affairs Counsel

OTS-4004.3

AMENDATORY SECTION (Amending WSR 20-24-021, filed 11/20/20, effective 12/28/20)

WAC 357-25-027 What must be included in the agency's sexual harassment policy? Agencies as defined in RCW 41.06.020 must at a minimum include the following in their policy on sexual harassment:

(1) Indicate who is covered by the policy;

(2) Provide that the employer is committed to providing a working environment free from sexual harassment of any kind;

(3) A statement that sexual harassment is an unlawful employment practice prohibited by Title VII of the Civil Rights Act of 1964 and RCW 49.60;

(4) The definition of sexual harassment as defined by the Equal Employment Opportunity Commission;

(5) Notify the employee or individual of their right to file a complaint with the Washington State Human Rights Commission under RCW 49.60.230 or the Federal Equal Employment Opportunity Commission under Title VII of the Civil Rights Act of 1964;

(6) Identify how and to whom employees or individuals may raise concerns or file complaints. The policy should allow multiple avenues for an employee or individual to raise complaints or concerns and should clearly identify the positions or entities charged with receiving these complaints;

(7) Advise all individuals covered by the policy that the employer is under a legal obligation to respond to allegations concerning a violation of the policy;

(8) Identify the manner by which the employer will respond to alleged violations of the policy, including a formal investigation if necessary;

(9) A statement that the complainant shall be informed of the status and the outcome of an investigation;

(10) Identify the agency's investigation or response procedure;

(11) Define the roles and responsibilities of employees, managers, supervisors, and others covered by the policy with respect to the following:

(a) Preventing or not engaging in sexual harassment;

(b) Responding to concerns or allegations of violations of the policy;

(c) Participation in an investigation under the policy; and

(d) The prohibition against retaliation.

(12) A statement that confidentiality cannot be guaranteed;

(13) A statement that responses to public records requests will be provided in accordance with RCW 42.56.660 and 42.56.675;

(14) Advise that retaliation against individuals covered by the policy who report allegations of sexual harassment or who participate in an investigation is prohibited;

(15) Advise that any employee found to have violated the policy will be subject to corrective and/or disciplinary action, up to and including dismissal;

(16) Advise that any employee found to have retaliated against individuals covered by the policy who report allegations of sexual harassment or who participate in an investigation will be subject to corrective and/or disciplinary action, up to and including dismissal; and

(17) A statement that an employer may not require an employee((~~,~~ ~~as a condition of employment, to sign a nondisclosure agreement, waiver, or other document that prevents the employee from disclosing sexual harassment or sexual assault occurring in the workplace, at work-related events coordinated by or through the employer, or between employees, or between an employer and an employee, off the employment premises in accordance with RCW 49.44.210~~)) to sign an agreement that prevents the employee from disclosing or discussing conduct or the existence of a settlement involving conduct described in RCW 49.44.211 and that it is a violation for the employer to discharge or otherwise discriminate or retaliate against the employee for disclosing or discussing such conduct.

For the purposes of this subsection, "employee" has the same meaning as defined in RCW ((~~49.44.210~~)) 49.44.211.

WSR 24-18-067
PERMANENT RULES
OFFICE OF
FINANCIAL MANAGEMENT

[Filed August 29, 2024, 10:43 a.m., effective October 1, 2024]

Effective Date of Rule: October 1, 2024.

Purpose: During the COVID-19 response, some general government employers encountered shortages of employees in segments of their operations, while other agencies had employees with the capacity and skill sets that could have been redeployed to address the staffing shortages. These amendments to the civil service rules (Title 357 WAC) provide a mechanism for general government employers to redeploy an employee within or between general government employers in the same or different job class with the same or different salary range maximum for a limited duration to support staffing shortages during an emergency or a disaster for the preservation of public health, safety, or general welfare. The repeal of WAC 357-19-165 is to remove redundant language and the amendment to WAC 357-19-353 is to also reflect gender-neutral pronouns.

Citation of Rules Affected by this Order: New WAC 357-01-277, 357-04-124, 357-19-179, 357-28-148 and 357-58-128; repealing WAC 357-19-165; and amending WAC 357-19-073, 357-19-080, 357-19-085, 357-19-353, 357-19-360, 357-19-365, 357-19-370, 357-19-388, 357-19-395, 357-19-430, 357-58-065, 357-58-225, 357-58-226, 357-58-265, 357-58-270, and 357-58-275.

Statutory Authority for Adoption: RCW 41.06.150.

Adopted under notice filed as WSR 24-14-106 on July 1, 2024.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 5, Amended 16, Repealed 1.

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

Number of Sections Adopted on the Agency's own Initiative: New 5, Amended 16, Repealed 1.

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

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 5, Amended 16, Repealed 1.

Date Adopted: August 29, 2024.

Nathan Sherrard
Legal Affairs Counsel

OTS-5112.1

NEW SECTION

WAC 357-01-277 Redeployment. A general government employer-initiated movement of an employee within or between general government employers in the same or different job class with the same or different salary range maximum for a limited duration to support staffing

shortages during an emergency or disaster in accordance with WAC 357-04-124.

OTS-5113.2

NEW SECTION

WAC 357-04-124 When may a general government employer request director approval to redeploy an employee during an emergency or disaster? During an emergency or a disaster, a general government employer may request director approval to redeploy an employee within or between general government employers for the preservation of public health, safety, or general welfare. The employee must have the necessary skills, abilities, and/or licensure in order to be redeployed. For purposes of this section, emergency or disaster has the same meaning as in RCW 38.52.010.

OTS-5114.5

AMENDATORY SECTION (Amending WSR 09-11-064, filed 5/14/09, effective 6/16/09)

WAC 357-19-073 What happens if an employee who is serving a probationary period accepts a nonpermanent appointment? (1) If an employee who is serving a probationary period accepts a nonpermanent appointment for reasons specified in WAC 357-19-360(1), the probationary period will end and the employee will not be granted permanent status unless the employer agrees to return the employee to a position at the conclusion of the nonpermanent appointment. Any return rights granted by the employer must be to a vacant position in the class in which the employee was serving a probationary period. If the employer chooses to grant the employee a return right, the employer must notify the employee in writing.

(2) If a general government employee who is serving a probationary period is redeployed into a nonpermanent appointment for reasons specified in WAC 357-19-360(2), the employer must return the employee to the same position held prior to the redeployment at the conclusion of the redeployment. Upon return to their previous position, the employee's base salary must be set at the step the employee would be at if they had not left the position.

(3) Upon return from a nonpermanent appointment the employee will resume their probationary period. If the employer determines the position the employee was serving a probationary period in and the position the employee was appointed to on a nonpermanent basis are allocated to classes which are closely related, the employer may count the time worked in the nonpermanent appointment towards the probationary period.

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

WAC 357-19-080 What happens if a permanent employee accepts a nonpermanent appointment during a trial service period? (1) If a permanent employee accepts a nonpermanent appointment for reasons specified in WAC 357-19-360(1) during a trial service period and the employer has agreed to return the employee to a position at the conclusion of the nonpermanent appointment, the employer may:

((~~(1)~~)) (a) Suspend the trial service period and allow the employee to resume the trial service period when the employee returns from the nonpermanent appointment;

((~~(2)~~)) (b) Require the trial service period to start over when the employee returns from the nonpermanent appointment; or

((~~(3)~~)) (c) Count the time worked in the nonpermanent appointment towards the trial service period.

(2) If a permanent general government employee is redeployed into a nonpermanent appointment for reasons specified in WAC 357-19-360(2) during a trial service period, the employer must return the employee to the same position held prior to the redeployment at the conclusion of the redeployment and the employer must count time worked in the nonpermanent appointment towards the trial service period for the permanent position. Upon return to their previous position, the employee's base salary must be set at the step the employee would be at if they had not left the position.

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

WAC 357-19-085 Does time worked in a nonpermanent appointment count towards the probationary or trial service period for a permanent position? (1) If an employee in a nonpermanent appointment for reasons specified in WAC 357-19-360(1) is subsequently appointed permanently to the same or a similar position, the employer may count time worked in the nonpermanent appointment towards the probationary or trial service period for the permanent position.

(2) If a general government employee in a nonpermanent appointment for reasons specified in WAC 357-19-360(2) is subsequently appointed permanently to the same or similar position, the employer may count time worked in the nonpermanent appointment towards the probationary period and must count time worked in the nonpermanent appointment towards the trial service period for the permanent position.

NEW SECTION

WAC 357-19-179 What provisions apply when a general government employee in classified service is redeployed to a different geographic area? When a general government employee in classified service is redeployed to a position in a different geographic area, the following applies:

(1) If the redeployment is within a reasonable commute of the employee's domicile, they may be redeployed without the employee's agreement.

(2) If the redeployment is outside of a reasonable commute of the employee's domicile, they may only be redeployed with the employee's consent.

For purposes of this section, the general government employer initiating the redeployment defines what is within a reasonable commute.

AMENDATORY SECTION (Amending WSR 05-12-094, filed 5/27/05, effective 7/1/05)

WAC 357-19-353 What return rights must an employer provide to a ((~~permanent~~)) WGS employee who accepts an acting WMS appointment? (1) At a minimum, the employer must provide the permanent employee who is leaving a WGS position with the employer to accept a WMS acting appointment for reasons specified in WAC 357-58-265 (1)(a) access to the employer's internal layoff list at the conclusion of the acting appointment. If the employer agrees to return the employee to a position, the employee must notify the employer of ((~~his/her~~)) their intent to return to a permanent position at least ((~~fourteen (14)~~)) 14 calendar days in advance of return unless the employee and employer agree otherwise. Failure of the employee to provide proper written notice to the employer may result in forfeiture of any return rights. Upon return to a permanent position, the employee's salary must be determined by the employer's salary determination policy.

(2) A general government employer must return an employee who was redeployed for reasons specified in WAC 357-58-265 (1)(b) to the same WGS position held prior to the redeployment at the conclusion of the redeployment. Upon return to their previous position, the employee's base salary is set at the step the employee would be at if they had not left the position.

AMENDATORY SECTION (Amending WSR 21-14-042 and 22-01-153, filed 6/30/21 and 12/15/21, effective 7/1/22)

WAC 357-19-360 For what reasons may an employer make nonpermanent appointments? (1) An employer may fill a position with a nonpermanent appointment when any of the following conditions exist:

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

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

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

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

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

(2) A general government employer may fill a position with a nonpermanent appointment when the director has given approval to redeploy an employee in accordance with WAC 357-04-124.

AMENDATORY SECTION (Amending WSR 21-14-042 and 22-01-153, filed 6/30/21 and 12/15/21, effective 7/1/22)

WAC 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? Employers **must not** fill a position with a nonpermanent appointment under the provisions of WAC 357-19-360((~~(3)~~)) (1)(c) 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 21-14-042 and 22-01-153, filed 6/30/21 and 12/15/21, effective 7/1/22)

WAC 357-19-370 How long may a nonpermanent appointment last? (1) Employers are encouraged to limit the duration of ((~~a~~)) nonpermanent appointments for reasons specified in WAC 357-19-360(1) to ((~~twelve~~)) 12 months from the appointment date.

(2) A nonpermanent appointment for a reason specified in WAC 357-19-360 (1) ((~~through (4)~~)) (a) through (d) **must not** exceed ((~~twenty-four~~)) 24 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~~)) 24-month limit. On-the-job training is not considered a formal training program for purposes of this rule.

(3) A nonpermanent appointment specified in WAC 357-19-360(2) **must not** exceed three months unless a longer duration is mutually agreed upon between the employee and general government employer(s) and conditions continue to exist in accordance with WAC 357-04-124. Appointments must not exceed 24 months unless the director has approved an extension of the appointment.

AMENDATORY SECTION (Amending WSR 21-14-042 and 22-01-153, filed 6/30/21 and 12/15/21, effective 7/1/22)

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 for reasons specified in WAC 357-19-360(1) must give their current employers at least ((~~fourteen~~)) 14 calendar days' notice before moving to a nonpermanent appointment. The current 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 employer must notify the employee in writing of 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 05-12-095, filed 5/27/05, effective 7/1/05)

WAC 357-19-395 What return rights must an employer provide to ((~~a permanent~~)) an employee who accepts a nonpermanent appointment? (1) For nonpermanent appointments made for reasons specified in WAC 357-19-360(1) at a minimum, the employer must provide the permanent employee who is leaving ((~~his/her~~)) their position with the employer to accept a nonpermanent appointment access to the employer's internal layoff list at the conclusion of the nonpermanent appointment. If the employer agrees to return the employee to a position, the employee must notify the employer of ((~~his/her~~)) their intent to return to a permanent position at least ((~~fourteen~~)) 14 calendar days in advance of return unless the employee and employer agree otherwise. Failure of the employee to provide proper written notice to the employer may result in forfeiture of any return rights. Upon return to a permanent position, the employee's salary must be determined by the employer's salary determination policy.

(2) For nonpermanent appointments made for reasons specified in WAC 357-19-360(2), the general government employee must be returned to the same position held prior to the redeployment at the conclusion of the redeployment. Upon return to their previous position, the employee's base salary must be set at the step the employee would be at if they had not left the position.

AMENDATORY SECTION (Amending WSR 21-14-042 and 22-01-153, filed 6/30/21 and 12/15/21, effective 7/1/22)

WAC 357-19-430 When may the director take remedial action for 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)(a) through ((~~(4)~~)) (d) and 357-19-360(2) has exceeded ((~~twenty-four~~)) 24 months without director approval.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 357-19-165	What is the difference between reassignment and transfer?

OTS-5115.1

NEW SECTION

WAC 357-28-148 How is a general government employee's salary determined when the employee is redeployed for reasons specified in WAC 357-19-360(2)? The base salary of a general government employee appointed to a position for reasons specified in WAC 357-19-360(2) must be determined as follows:

(1) An employee who is redeployed to a position with the same salary range keeps the same base salary.

(2) An employee who is redeployed to a position with a lower salary range maximum must be placed within the new range at a salary equal to the employee's previous base salary. If the employee's previous base salary exceeds the new salary range, the employee's base salary may be set higher than step M but not exceeding their prior base salary.

(3) An employee who is redeployed to a position with a higher salary range must have their salary set in accordance with WAC 357-28-110.

OTS-5116.4

AMENDATORY SECTION (Amending WSR 22-12-074, filed 5/27/22, effective 7/1/22)

WAC 357-58-065 Definitions for WMS. The following definitions apply to chapter 357-58 WAC:

(1) **Break in service.** An employee has a break in continuous state service if the employee is separated, dismissed or resigns from state service. A furlough for the purposes of temporary layoff as provided in WAC 357-58-550 is not considered a break in continuous state service.

(2) **Choice performance confirmation.** Approval granted by the director to an employer allowing the employer to factor in individual employee performance when granting recognition leave.

(3) **Competencies.** Those measurable or observable knowledge, skills, abilities and behaviors critical to success in a key job role or function.

(4) **Director.** State human resources director within the office of financial management.

(5) **Dismissal.** The termination of an individual's employment for disciplinary reasons.

(6) **Employee.** An individual working in the classified service. Employee business unit members are defined in WAC 357-43-001.

(7) **Evaluation points.** The points resulting from an evaluation of a position using the managerial job value assessment chart.

(8) **Layoff unit.** A clearly identified structure within an employer's organization within which layoff options are determined in accordance with the employer's layoff procedure. Layoff units may be a series of progressively larger units within an employer's organization.

(9) **Management bands.** A series of management levels included in the WMS. Placement in a band reflects the nature of management, deci-

sion-making environment and policy impact and scope of management accountability and control assigned to the position.

(10) **Premium.** Pay added to an employee's base salary on a contingent basis in recognition of special requirements, conditions or circumstances associated with the job.

(11) **Reassignment.** An employer-initiated movement of:

(a) A WMS employee from one position to a different position within WMS with the same salary standard and/or evaluation points; or

(b) A WMS position and the employee in that position from one section, department or geographical location to another section, department or geographical location.

(12) **Redeployment.** An employer-initiated movement of a WMS employee within or between general government employers to a position in the same or different salary standard and/or evaluation points for a limited duration to support staffing shortages during an emergency or disaster in accordance with WAC 357-04-124.

(13) **Review period.** A period of time that allows the employer an opportunity to ensure the WMS employee meets the requirements and performance standards of the position.

((~~(13)~~)) (14) **Salary standard.** Within a management band a salary standard is the maximum dollar amount assigned to a position in those agencies that use a salary standard in addition to, or in place of, evaluation points.

((~~(14)~~)) (15) **Separation.** Separation from state employment for nondisciplinary reasons.

((~~(15)~~)) (16) **Suspension.** An absence without pay for disciplinary reasons.

((~~(16)~~)) (17) **Transfer.** An employee-initiated movement from one position to a different position with the same salary standard and/or same evaluation points.

((~~(17)~~)) (18) **Veterans placement program.** A program that is designated to grant transitioning service members and veterans additional support to attain state employment.

((~~(18)~~)) (19) **Washington general service (WGS).** The system of personnel administration that applies to classified employees or positions under the jurisdiction of chapter 41.06 RCW which do not meet the definition of manager found in RCW 41.06.022.

((~~(19)~~)) (20) **Washington management service (WMS).** The system of personnel administration that applies to classified managerial employees or positions under the jurisdiction of RCW 41.06.022 and 41.06.500.

NEW SECTION

WAC 357-58-128 How is a WMS employee's salary determined when the employee is redeployed for reasons specified in WAC 357-58-265(2)? The base salary of a WMS employee appointed to a position for reasons specified in WAC 357-58-265(2) must be determined as follows:

(1) A WMS employee who is redeployed to a position with the same salary standard keeps the same base salary.

(2) A WMS employee who is redeployed to a position with a lower salary standard maximum must be placed within the new salary standard at a salary equal to the employee's previous base salary. If the previous base salary exceeds the new salary standard, the employee's base

salary may be set higher than associated salary standard but not exceeding their prior base salary.

(3) A WMS employee who is redeployed to a position with a higher salary standard must receive a salary increase nearest to five percent or up to the minimum of the new salary standard, whichever is greatest, not to exceed the new management band maximum.

AMENDATORY SECTION (Amending WSR 19-11-136, filed 5/22/19, effective 7/1/19)

WAC 357-58-225 What return rights must an employer provide to a ((~~permanent~~)) WMS employee who accepts a nonpermanent appointment to a WGS position? (1) For nonpermanent appointments made for reasons specified in WAC 357-19-360(1) the following applies:

(a) When a permanent WMS employee has accepted a nonpermanent appointment to a WGS position within the **same** agency and the nonpermanent appointment ends, the agency must at a minimum provide the employee the layoff rights of the employee's permanent WMS position. If returning to a permanent WMS position the employee's salary must not be less than the salary of the previously held permanent WMS position.

((~~(2)~~)) (b) When a permanent WMS employee has accepted a nonpermanent appointment to a WGS position within a **different** agency, the original agency must provide layoff rights as specified in ((~~subsection (1)~~)) (a) of this ((~~section~~)) subsection for six months from the time the employee is appointed. Any return right after six months is negotiable between the employee and agency and must be agreed to prior to the employee accepting the nonpermanent appointment. If the employee does not return on the agreed upon date, the employee can request placement in the general government transition pool per WAC 357-46-095.

((~~(3)~~)) (c) In lieu of the rights provided in ((~~subsection (1) or (2)~~)) (a) or (b) of this ((~~section~~)) subsection, the agency and the employee may agree to other terms.

(2) For nonpermanent appointments made for reasons listed in WAC 357-19-360(2), the employee must be returned to the same position held prior to the redeployment at the conclusion of the nonpermanent appointment. Upon return to their previous position, the employee's base salary is set as if the employee had not left the position.

AMENDATORY SECTION (Amending WSR 14-06-007, filed 2/20/14, effective 3/24/14)

WAC 357-58-226 What happens when a WMS employee who was serving a review period and was appointed to a WGS nonpermanent position returns to ((~~the same or different~~)) a WMS position? (1) If a WMS employee was serving a review period ((~~and accepted~~)) accepts a nonpermanent appointment for reasons specified in WAC 357-19-360(1) to a WGS position and ((~~returned~~)) returns to the same or different WMS position, the employer may allow the prior time served in the WMS review period to count towards the completion of the review period.

(2) If a WMS employee who was serving a review period is redeployed into a WGS nonpermanent appointment in accordance with WAC 357-19-360(2), the employer must return the employee to the same posi-

tion held prior to the redeployment at the conclusion of the redeployment. The employer must count time worked in the nonpermanent appointment towards the completion of the review period for the permanent position.

AMENDATORY SECTION (Amending WSR 05-12-070, filed 5/27/05, effective 7/1/05)

WAC 357-58-265 When may an agency make an acting WMS appointment and what actions are required? ((~~When necessary to meet organizational needs,~~)) (1) An agency may make nonpermanent appointments in WMS((~~.~~ ~~These appointments~~)) which are called acting appointments. Acting WMS appointments can be made when any of the following conditions exist:

(a) When necessary to meet organization needs; or

(b) When approval has been granted by the director to redeploy an employee in accordance with WAC 357-04-124.

(2) Prior to the acting appointment, the appointing authority must communicate in writing to the employee the anticipated length, intent, salary, and other conditions of the appointment.

AMENDATORY SECTION (Amending WSR 05-12-070, filed 5/27/05, effective 7/1/05)

WAC 357-58-270 Does time in an acting appointment count as time in the review period? (1) When an individual who is in an acting WMS appointment for reasons specified in WAC 357-58-265 (1)(a) is subsequently appointed to a permanent WMS position, time spent in the acting appointment may count towards the review period for the permanent WMS position at the discretion of the appointing authority.

(2) When an individual who is in an acting WMS appointment for reasons specified in WAC 357-58-265 (1)(b) is subsequently appointed to the same or similar permanent WMS position, time spent in the acting appointment must count towards the review period for the permanent WMS position.

AMENDATORY SECTION (Amending WSR 19-11-136, filed 5/22/19, effective 7/1/19)

WAC 357-58-275 May a ((~~permanent~~)) WMS employee accept an acting WMS appointment and what are the employee's return rights at the conclusion of the acting appointment? (1) Permanent WMS employees may accept acting appointments to WMS positions for reasons specified in WAC 357-58-265 (1)(a).

((~~(1)~~)) (a) When a permanent WMS employee has accepted an acting appointment within the **same** agency and the acting appointment ends the following applies:

((~~(a)~~)) (i) The agency may agree to return the employee to a permanent WMS position. If returning to a permanent WMS position, the employee's salary must not be less than the salary of the previously held permanent WMS position.

((~~(b)~~)) (ii) The agency at a minimum must provide the employee the layoff rights of the employee's permanent WMS position in accordance with WAC 357-58-465.

((~~(2)~~)) (b) When a permanent WMS employee has accepted an acting appointment within a **different** agency, the original agency must provide layoff rights as specified in ((~~subsection (1)~~)) (a) of this ((~~section~~)) subsection for six months from the time the employee is appointed. Any return right after six months is negotiable between the employee and agency and must be agreed to prior to the employee accepting the nonpermanent appointment. If the employee does not return on the agreed upon date, the employee can request placement in the general government transition pool per WAC 357-46-095.

((~~(3)~~)) (c) In lieu of the rights provided in ((~~subsections (1) and (2)~~)) (a) and (b) of this ((~~section~~)) subsection, the agency and the employee may agree to other terms.

(2) When a WMS employee has been redeployed into an acting WMS position for reasons specified in WAC 357-58-265 (1)(b), the employee must be returned to the same position held prior to the redeployment at the conclusion of the acting appointment. Upon return to their previous position, the employee's base salary is set as if the employee had not left the position.

WSR 24-18-068
PERMANENT RULES
OFFICE OF
FINANCIAL MANAGEMENT

[Filed August 29, 2024, 10:43 a.m., effective October 1, 2024]

Effective Date of Rule: October 1, 2024.

Purpose: To align Title 357 WAC with the requirements in 2SHB 2014, chapter 146, Laws of 2024. 2SHB 2014 passed during the 2024 legislative session, effective June 6, 2024, for sections 1-24. This bill intends to align the federal and state definitions of "veteran" expanding state veterans benefits to any veteran who is already eligible for federal Department of Veterans Affairs monetary benefits. Section 4 of the bill adds a new section to chapter 73.04 RCW, codified as RCW 73.04.055, to define "qualifying discharge." "Honorable discharge" is replaced with "qualifying discharge" throughout the bill. The proposed amendments to WAC 357-01-170 repeal language stating veterans scoring criteria is only added to passing scores since there is more than one way for an eligible candidate to receive preference credits. The new WAC 357-01-267 provides a definition of "qualifying discharge." The amendments to WAC 357-16-110 clarify veterans scoring criteria is only added to passing scores, replaces "honorable discharge" with "qualifying discharge," and adds clarification that veterans must have a qualifying discharge. The amendments to WAC 357-46-060 and 357-58-475 update the definition of eligible veteran by replacing "honorable discharge" with "qualifying discharge" and remove existing criteria tied to an "honorable discharge."

Citation of Rules Affected by this Order: New WAC 357-01-267; and amending WAC 357-01-170, 357-16-110, 357-46-060, and 357-58-475.

Statutory Authority for Adoption: RCW 41.06.133.

Other Authority: RCW 73.04.055.

Adopted under notice filed as WSR 24-14-108 on July 1, 2024.

Changes Other than Editing from Proposed to Adopted Version: Amendment to WAC 357-01-267 to update the reference from "section 4, chapter 146, Laws of 2024" to "RCW 73.04.005."

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 1, Amended 4, Repealed 0.

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

Number of Sections Adopted on the Agency's own Initiative: New 1, Amended 4, Repealed 0.

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

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 1, Amended 4, Repealed 0.

Date Adopted: August 29, 2024.

Nathan Sherrard
Legal Affairs Counsel

OTS-5407.3

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

WAC 357-01-170 Examination results. An eligible candidate's final score on an examination, plus any veteran's scoring criteria or other applicable credits. ((~~Veterans scoring criteria is only added to passing scores.~~))

NEW SECTION

WAC 357-01-267 Qualifying discharge. "Qualifying discharge" has the same meaning as in RCW 73.04.005.

OTS-5408.2

AMENDATORY SECTION (Amending WSR 09-17-057 and 09-18-112, filed 8/13/09 and 9/2/09, effective 12/3/09)

WAC 357-16-110 Do veterans receive any preference in the hiring process? (1) If an employer is administering an examination prior to certification, the employer must grant preference to veterans in accordance with the veterans scoring criteria provisions of RCW 41.04.010. Veterans' scoring criteria is only added to passing scores.

(2) If no examination is administered prior to certification, the employer must refer the following individuals to the employing official under the provisions of RCW 73.16.010 as long as the individual meets the competencies and other position requirements:

(a) Eligible veterans with a qualifying discharge;

(b) Surviving spouses or registered domestic partners of eligible veterans with a qualifying discharge; or

(c) Spouses or registered domestic partners of ((~~honorably discharged~~)) veterans with a qualifying discharge who have a service-connected permanent and total disability.

OTS-5409.1

AMENDATORY SECTION (Amending WSR 16-17-091, filed 8/18/16, effective 9/20/16)

WAC 357-46-060 Does a veteran receive any preference in layoff? (1) An eligible veteran receives a preference in layoff by having their seniority increased for total active military service, not to exceed five years.

(2) An eligible veteran is defined as any permanent employee who:

(a) Has one or more years in active military service in any branch of the armed forces of the United States or who has less than one year's service and is discharged with a disability incurred in the

line of duty or is discharged at the convenience of the government; and

(b) ((~~Has received,~~)) Upon termination of such service((~~:~~

~~(i) An honorable discharge;~~

~~(ii) A discharge for physical reasons with an honorable record; or~~

~~(iii) A release from active military service with evidence of service other than that for which an undesirable, bad conduct, or dishonorable discharge is given~~)) has received a qualifying discharge.

(3) "An eligible veteran" does not include any person who as a veteran voluntarily retired, as evidenced by the "DD Form 214" or other official military records, with ((~~twenty~~)) 20 or more years' active military service and has military retirement pay in excess of ((~~five hundred dollars~~)) $500 per month.

(4) The surviving spouse or surviving registered domestic partner of an eligible veteran is entitled to veteran's seniority preference for up to five years as outlined in subsections (1) and (2) of this section regardless of whether the veteran had at least one year of active military service.

OTS-5410.1

AMENDATORY SECTION (Amending WSR 16-17-091, filed 8/18/16, effective 9/20/16)

WAC 357-58-475 Does a veteran receive any preference in layoff? (1) An eligible veteran receives a preference in layoff by having their seniority increased for total active military service, not to exceed five years.

(2) An eligible veteran is defined as any permanent employee who:

(a) Has one or more years in active military service in any branch of the armed forces of the United States or who has less than one year's service and is discharged with a disability incurred in the line of duty or is discharged at the convenience of the government; and

(b) ((~~Has received,~~)) Upon termination of such service((~~:~~

~~(i) An honorable discharge;~~

~~(ii) A discharge for physical reasons with an honorable record; or~~

~~(iii) A release from active military service with evidence of service other than that for which an undesirable, bad conduct, or dishonorable discharge is given~~)) has received a qualifying discharge.

(3) "An eligible veteran" does not include any person who as a veteran voluntarily retired with ((~~twenty~~)) 20 or more years' active military service and has military retirement pay in excess of ((~~five hundred dollars~~)) $500 per month.

(4) The surviving spouse or surviving registered domestic partner of an eligible veteran is entitled to veteran's seniority preference for up to five years as outlined in subsections (1) and (2) of this section regardless of whether the veteran had at least one year of active military service.

WSR 24-18-069
PERMANENT RULES
OFFICE OF
FINANCIAL MANAGEMENT

[Filed August 29, 2024, 10:44 a.m., effective October 1, 2024]

Effective Date of Rule: October 1, 2024.

Purpose: To align chapters 357-01 and 357-31 WAC with the requirements in HB 2246, chapter 151, Laws of 2024. HB 2246 passed during the 2024 legislative session, with an effective date of June 6, 2024. Section 1 of this bill amends RCW 43.01.040 to increase the annual cap on the accrual of unused vacation leave for state employees from 240 hours to 280 hours. Section 2 of this bill amends RCW 43.01.044 to increase the amount of unused vacation leave that can be deferred above the maximum from 240 to 280 hours. The amendments to WAC 357-01-022 and 357-01-023 are to increase the amount of unused vacation hours higher education and general government employees may accumulate before it is lost on their anniversary date; other amendments to WAC 357-01-022 are housekeeping in nature. The amendments to WAC 357-31-210 update the maximum number of vacation leave hours an employee may accumulate from 240 to 280 hours without an exception. The amendments to WAC 357-31-215 address when an employee may accumulate vacation leave above the maximum amount of 280 hours, housekeeping amendments, and to reflect gender-neutral pronouns.

Citation of Rules Affected by this Order: Amending WAC 357-01-022, 357-01-023, 357-31-210, and 357-31-215.

Statutory Authority for Adoption: RCW 41.06.133.

Other Authority: RCW 43.01.040 and 43.01.044.

Adopted under notice filed as WSR 24-14-107 on July 1, 2024.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 4, Repealed 0.

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

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 4, Repealed 0.

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

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 4, Repealed 0.

Date Adopted: August 29, 2024.

Nathan Sherrard
Legal Affairs Counsel

OTS-5367.2

AMENDATORY SECTION (Amending WSR 05-12-093, filed 5/27/05, effective 7/1/05)

WAC 357-01-022 Anniversary date (higher education). For employees of higher education institutions or related higher education

boards, anniversary date is the most recent date of hire into state service. The anniversary date is used to determine when vacation leave over ((~~two hundred forty (240)~~)) 280 hours is lost. Higher education employers may make the anniversary date the first calendar day of the month in which the date of hire occurred. A higher education employee receives a new anniversary date when that employee is rehired following a break in state service, but not when the employee ((~~promotes, demotes, or transfers~~)) is promoted, demoted, or transferred to another higher education employer.

AMENDATORY SECTION (Amending WSR 22-06-006, filed 2/17/22, effective 7/1/22)

WAC 357-01-023 Anniversary date (general government). For employees of general government agencies, anniversary date is the unbroken service date plus prior state service. The anniversary date is used to determine when vacation leave over ((~~two hundred forty~~)) 280 hours is lost and for computing the rate of vacation leave accrual beginning with the fifth year of total state employment.

OTS-5368.2

AMENDATORY SECTION (Amending WSR 17-18-028, filed 8/28/17, effective 10/2/17)

WAC 357-31-210 What is the maximum number of hours of vacation leave that an employee ((~~can~~)) may accumulate? Vacation leave may be accumulated to a maximum of ((~~two hundred forty~~)) 280 hours. Exceptions to this maximum are described in WAC 357-31-215.

AMENDATORY SECTION (Amending WSR 17-18-028, filed 8/28/17, effective 10/2/17)

WAC 357-31-215 When may vacation leave be accumulated above the maximum ((~~two hundred forty~~)) 280 hours? There are two circumstances in which vacation leave may be accumulated above the maximum of ((~~two hundred forty~~)) 280 hours.

(1) If an employee's request for vacation leave is denied by the employer, and the employee is close to the maximum vacation leave (((~~two hundred forty~~)) 280 hours), the employer must grant an extension for each month that the employer defers the employee's request for vacation leave. The employer must maintain a statement of necessity justifying the extension.

(2) As an alternative to subsection (1) of this section, employees may also accumulate vacation leave in excess of ((~~two hundred forty~~)) 280 hours as follows:

(a) An employee may accumulate the vacation leave hours between the time the ((~~two hundred forty~~)) 280 hours is accrued and ((~~his/her~~)) their next anniversary date of state employment.

(b) Leave accumulated above ((~~two hundred forty~~)) 280 hours must be used by the next anniversary date and in accordance with the employer's leave policy. If such leave is not used before the employee's anniversary date, the excess leave is automatically lost and considered to have never existed.

(c) A statement of necessity, as described in subsection (1) of this section, can only defer leave that the employee has not accrued as of the date of the statement of necessity. Any accrued leave in excess of ((~~two hundred forty~~)) 280 hours as of the date of the statement of necessity cannot be deferred regardless of circumstances. For example:

On June 15th, an employee is assigned to work on a special project. It is expected that the assignment will last six months. Due to an ambitious timeline and strict deadlines, the employee will not be able to take any vacation leave during that time.

• On June 15th, the employee's vacation leave balance is ((~~two hundred sixty~~)) 300 hours.

• The employee accrues ((~~ten~~)) 10 hours monthly.

• The employee's anniversary date is October 16th.

Because the employee will not be able to use leave from June 15th through December 15th the employee files a statement of necessity asking to defer the leave accrued during this time. This deferred leave will not be lost as long as the employee uses the deferred hours by their next anniversary date (October 16th of the following year).

The ((~~twenty~~)) 20 hours of excess vacation leave the employee had on June 15th are not covered by the statement of necessity.

WSR 24-18-070
PERMANENT RULES
OFFICE OF
FINANCIAL MANAGEMENT

[Filed August 29, 2024, 10:45 a.m., effective October 1, 2024]

Effective Date of Rule: October 1, 2024.

Purpose: The amendments to WAC 357-31-165(1) and 357-31-166(1) are housekeeping in nature and align with the WAC style guide. The amendment to WAC 357-31-165(2) is to align with the intent of the original rule making to allow employers to have flexibility to authorize a lump-sum accrual of vacation leave and/or accelerate the vacation leave accrual rate. This was an oversight when WAC 357-31-165 was originally adopted and this amendment aligns with WAC 357-58-175. The amendment to WAC 357-31-165 (3)(b) is to mirror the language in WAC 357-31-166 (3)(b) to provide clarity that employment exempt by the provisions of WAC 357-04-040, 357-04-045, 357-04-050, and 357-04-055 is not credited for the purposes of computing the rate of vacation leave accrual. The amendment to WAC 357-31-165 (3)(c) is to clarify exempt employment with an employer (not just limited to a general government employer as previously stated) is credited when computing a general government employee's rate of vacation leave accrual. The amendment to WAC 357-31-166 (3)(a) is to replace language from "full-time faculty and/or administrative exempt" to "exempt academic and professional personnel" in order to provide clarity and for consistency to align with higher education institution practice. The amendments to WAC 357-31-166 (3)(c) and (d) are to mirror the language in WAC 357-31-165(3). The amendments to WAC 357-46-067, 357-58-470, and 357-58-554 are to remove obsolete language. The amendments to WAC 357-58-175 are to replace "can" with "may" and "or" with "and/or" in the WAC title for consistency with the body of the WAC and to meet the original intent of the rule, and to match the body of the WAC with the title of the WAC. The amendments to WAC 357-58-180 are to align the title of the WAC with the body of the WAC to meet the original intent of the rule. The amendment to WAC 357-58-210 is to correct the reference from "management band" to "same salary standard and/or same evaluation points."

Citation of Rules Affected by this Order: Amending WAC 357-31-165, 357-31-166, 357-46-067, 357-58-175, 357-58-180, 357-58-210, 357-58-470, and 357-58-554.

Statutory Authority for Adoption: RCW 41.06.133.

Adopted under notice filed as WSR 24-14-104 on July 1, 2024.

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

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

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 8, Repealed 0.

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

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 8, Repealed 0.

Date Adopted: August 29, 2024.

Nathan Sherrard

OTS-5432.1

AMENDATORY SECTION (Amending WSR 19-11-136, filed 5/22/19, effective 7/1/19)

WAC 357-31-165 At what rate do general government employees accrue vacation leave? (1) Full-time general government employees accrue vacation leave at the following rates:

(a) During the first and second years of current continuous state employment - Nine hours, ((~~twenty~~)) 20 minutes per month;

(b) During the third year of current continuous state employment - ((~~Ten~~)) 10 hours per month;

(c) During the fourth year of current continuous state employment - ((~~Ten~~)) 10 hours, ((~~forty~~)) 40 minutes per month;

(d) During the fifth and sixth years of total state employment - ((~~Eleven~~)) 11 hours, ((~~twenty~~)) 20 minutes per month;

(e) During the seventh, eighth, and ninth years of total state employment - ((~~Twelve~~)) 12 hours per month;

(f) During the ((~~tenth, eleventh, twelfth, thirteenth and fourteenth~~)) 10th, 11th, 12th, 13th, and 14th years of total state employment - ((~~Thirteen~~)) 13 hours, ((~~twenty~~)) 20 minutes per month;

(g) During the ((~~fifteenth, sixteenth, seventeenth, eighteenth and nineteenth~~)) 15th, 16th, 17th, 18th, and 19th years of total state employment - ((~~Fourteen~~)) 14 hours, ((~~forty~~)) 40 minutes per month;

(h) During the ((~~twentieth, twenty-first, twenty-second, twenty-third and twenty-fourth~~)) 20th, 21st, 22nd, 23rd, and 24th years of total state employment - ((~~Sixteen~~)) 16 hours per month; and

(i) During the ((~~twenty-fifth~~)) 25th and succeeding years of total state employment - ((~~Sixteen~~)) 16 hours, ((~~forty~~)) 40 minutes per month.

(2) As provided in WAC 357-58-175, an employer may authorize a lump-sum accrual of vacation leave and/or accelerate the vacation leave accrual rate to support the recruitment and/or retention of a candidate or employee for a WMS position. Vacation leave accrual rates may only be accelerated using the rates established in subsection (1) of this section and must not exceed the maximum listed in subsection (1)(i) of this section.

(3) The following applies for purposes of computing the rate of vacation leave accrual:

(a) Employment in the legislative and/or the judicial branch except for time spent as an elected official or in a judicial appointment is credited.

(b) Employment exempt by the provisions of WAC 357-04-040, 357-04-045, 357-04-050, 357-04-055 is not credited for the purposes of computing the rate of vacation leave accrual.

(c) Exempt employment with ((~~a general government~~)) an employer is credited, other than that specified in WAC 357-04-055 which is excluded.

AMENDATORY SECTION (Amending WSR 22-01-022, filed 12/3/21, effective 7/1/22)

WAC 357-31-166 At what rate do higher education employees accrue vacation leave? (1) Full-time higher education employees accrue vacation leave at the following rates:

(a) During the first year of continuous state employment - 12 days (eight hours per month);

(b) During the second year of continuous state employment - 13 days (eight hours, 40 minutes per month);

(c) During the third and fourth years of continuous state employment - 14 days (nine hours, 20 minutes per month);

(d) During the fifth, sixth, and seventh years of total state employment - 15 days (10 hours per month);

(e) During the eighth, ninth, and ((~~tenth~~)) 10th years of total state employment - 16 days (10 hours, 40 minutes per month);

(f) During the ((~~eleventh~~)) 11th year of total state employment - 17 days (11 hours, 20 minutes per month);

(g) During the ((~~twelfth~~)) 12th year of total state employment - 18 days (12 hours per month);

(h) During the ((~~thirteenth~~)) 13th year of total state employment - 19 days (12 hours, 40 minutes per month);

(i) During the ((~~fourteenth~~)) 14th year of total state employment - 20 days (13 hours, 20 minutes per month);

(j) During the ((~~fifteenth~~)) 15th year of total state employment - 21 days (14 hours per month);

(k) During the ((~~sixteenth~~)) 16th and succeeding years of total state employment - 22 days (14 hours, 40 minutes per month).

(2) Higher education employers may establish accrual rates that exceed the rates listed in subsection (1) of this section. This does not apply to individual positions.

(3) The following applies for purposes of computing the rate of vacation leave accrual:

(a) Each contract year, or equivalent, of ((~~full-time faculty and/or administrative~~)) exempt academic and professional personnel employment with a higher education employer is credited as one year of qualifying service.

((~~(4)~~)) (b) Employment exempt by the provisions of WAC 357-04-040, 357-04-045, 357-04-050, and 357-04-055 is not credited for the purposes of computing the rate of vacation leave accrual.

(c) Employment in the legislative and/or judicial branch except for time spent as an elected official or in a judicial appointment is credited.

(d) Exempt employment with a general government employer is credited, other than that specified in WAC 357-04-055 which is excluded.

OTS-5087.1

AMENDATORY SECTION (Amending WSR 12-04-016, filed 1/24/12, effective 2/24/12)

WAC 357-46-067 What is an employee's status during temporary layoff? (1) The following applies during a temporary layoff:

(a) An employee's anniversary, seniority, and unbroken service dates are not adjusted for periods of time spent on temporary layoff;

(b) An employee's vacation and sick leave accruals will not be impacted by periods of time spent on temporary layoff;

(c) An employee's holiday compensation will not be impacted by periods of time spent on temporary layoff; and

(d) The duration of an employee's probationary period or trial service period shall not be extended for periods of time spent on temporary layoff.

(2) An employee who is temporarily laid off is not entitled to:

(a) Layoff rights, including the ability to bump any other position or be placed on the employer's internal or statewide layoff list;

(b) Payment for their vacation leave balance; and

(c) Use of their accrued vacation leave for hours the employee is not scheduled to work if the temporary layoff was due to lack of funds. ((~~The only exception is that during the 2009-2011 fiscal biennium if an employee's monthly full-time equivalent base salary is two thousand five hundred dollars or less and the employee's office or institution enacts a temporary layoff as described in chapter 32, Laws of 2010, the employee can use accrued vacation leave during the period of temporary layoff.~~))

(3) If the temporary layoff was not due to lack of funds, an employer may allow an employee to use accrued vacation leave in lieu of temporary layoff.

OTS-5126.3

AMENDATORY SECTION (Amending WSR 19-11-136, filed 5/22/19, effective 7/1/19)

WAC 357-58-175 ((~~Can~~)) May an employer authorize lump sum vacation leave and/or accelerate vacation leave accrual rates to support the recruitment and/or retention of an employee or candidate for a WMS position? In addition to the vacation leave accruals as provided in WAC 357-31-165, an employer may authorize ((~~additional~~)) lump sum vacation leave and/or accelerate vacation leave accrual rates as follows to support the recruitment and/or retention of an employee or candidate for a specific WMS position:

(1) Employers may authorize an accelerated accrual rate for an employee or candidate. The WMS employee would remain at the accelerated accrual rate until the WMS employee's anniversary date caught up to the accrual rate amount in accordance with WAC 357-31-165; and/or

(2) Employers may authorize a lump sum accrual of up to ((~~eighty~~)) 80 hours of vacation leave for the employee or candidate.

Vacation leave accrued under this section must be used in accordance with the leave provisions of chapter 357-31 WAC.

AMENDATORY SECTION (Amending WSR 19-11-136, filed 5/22/19, effective 7/1/19)

WAC 357-58-180 Must an agency have a policy regarding authorization of additional vacation leave to support the recruitment ((~~of a~~)) and/or retention of an employee or candidate ((~~or the retention of an employee~~)) for a WMS position? In order to authorize additional vacation leave for the recruitment and/or retention of ((~~a candidate or~~)) an employee or a candidate for a WMS position, an agency must have a written policy that:

(1) Identifies the reasons for which the employer may authorize additional vacation leave; and

(2) Requires that lump sum vacation leave accruals only be granted after services have been rendered in accordance with express conditions established by the employer.

AMENDATORY SECTION (Amending WSR 19-11-136, filed 5/22/19, effective 7/1/19)

WAC 357-58-210 When may a WMS employee transfer to a WGS position and vice versa? A permanent employee may transfer from a WMS position to a WGS position if the employee's salary is within the salary range of the WGS position.

A permanent employee may transfer from a WGS position to a WMS position if the employee's salary is within the ((~~management band~~)) same salary standard and/or same evaluation points assigned to the WMS position.

AMENDATORY SECTION (Amending WSR 05-12-071, filed 5/27/05, effective 7/1/05)

WAC 357-58-470 How does an employer determine an employee's employment retention rating? The employer determines an employee's employment retention rating using seniority as calculated in WAC 357-46-055. ((~~Employers with performance management confirmation may consider properly documented performance in addition to seniority. If performance is not considered, an employee's employment retention rating is equal to the employee's seniority.~~))

AMENDATORY SECTION(Amending WSR 12-04-016, filed 1/24/12, effective 2/24/12)

WAC 357-58-554 What is a WMS employee's status during temporary layoff? (1) The following applies during a temporary layoff:

(a) An employee's anniversary date, seniority, or unbroken service date is not adjusted for periods of time spent on temporary layoff;

(b) An employee's vacation and sick leave accruals will not be impacted by periods of time spent on temporary layoff;

(c) An employee's holiday compensation will not be impacted by periods of time spent on temporary layoff; and

(d) The duration of an employee's review period shall not be extended for periods of time spent on temporary layoff.

(2) A WMS employee who is temporarily laid off is not entitled to:

(a) Layoff rights, including the ability to bump any other position or be placed on the employer's internal or statewide layoff list;

(b) Payment for their vacation leave balance; and

(c) Use of their accrued vacation leave for hours the employee is not scheduled to work if the temporary layoff was due to lack of funds. ((~~The only exception is that during the 2009-2011 fiscal biennium if an employee's monthly full-time equivalent base salary is two thousand five hundred dollars or less and the employee's agency enacts a temporary layoff as described in chapter 32, Laws of 2010, the employee can use accrued vacation leave during the period of temporary layoff.~~))

(3) If the temporary layoff was not due to lack of funds, an employer may allow a WMS employee to use accrued vacation leave in lieu of temporary layoff.

WSR 24-18-071
PERMANENT RULES
OFFICE OF
FINANCIAL MANAGEMENT

[Filed August 29, 2024, 10:46 a.m., effective October 1, 2024]

Effective Date of Rule: October 1, 2024.

Purpose: To align the civil service rules (Title 357 WAC) with the requirements in SSB 6157, chapter 330, Laws of 2024. SSB 6157 passed during the 2024 legislative session with an effective date of June 6, 2024. This bill intends to reform civil service by incorporating civil service advantage for bilingual and multilingual applicants, applicants with prior work experience in social services, and applicants with higher education. Section 1 adds a new section to chapter 41.04 RCW, codified as RCW 41.04.012, to state that in all competitive examinations to determine the qualifications of applicants, the agency head within a hiring organization has the discretion to add a maximum of 15 percent to the passing mark, grade, or rating only in accordance with outlined criteria. Preference points may not be aggregated to exceed more than 15 percent of an applicant's examination score; shall be added to the passing mark, grade, or rating of competitive examinations until the candidate's first appointment; and may not be used in promotional examinations. The bill also defines "full professional fluency" and "native speaker." New WAC 357-16-113 addresses when an agency head or higher education institution president may consider granting preference to eligible applicants in the hiring process. The amendment to WAC 357-16-125 requires an employer's certification procedure to address when the employer will consider granting preference to eligible applicants under the provisions of WAC 357-16-113. New WAC 357-58-197 addresses when may an agency head consider granting preference to eligible Washington management service applicants in the hiring process.

Citation of Rules Affected by this Order: New WAC 357-16-113 and 357-58-197; and amending WAC 357-16-125.

Statutory Authority for Adoption: RCW 41.06.150.

Other Authority: RCW 41.04.012.

Adopted under notice filed as WSR 24-14-103 on July 1, 2024.

Changes Other than Editing from Proposed to Adopted Version: Amendments to WAC 357-16-113 and 357-58-197 to include updated RCW references from "chapter 41.04 RCW" and "section 1, chapter 330, Laws of 2024" to "RCW 41.04.012."

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 2, Amended 1, Repealed 0.

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

Number of Sections Adopted on the Agency's own Initiative: New 2, Amended 1, Repealed 0.

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

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 2, Amended 1, Repealed 0.

Date Adopted: August 29, 2024.

Nathan Sherrard
Legal Affairs Counsel

OTS-5417.3

NEW SECTION

WAC 357-16-113 When may an agency head or higher education institution president consider granting preference to eligible applicants in the hiring process? (1) An agency head or higher education institution president may consider granting preference to eligible applicants in the hiring process if administering an examination prior to certification for any of the following qualifications in accordance with RCW 41.04.012:

(a) Ten percent to an applicant who has obtained full professional proficiency or who is completely fluent as a native speaker in two or more languages other than English;

(b) Five percent to an applicant who has obtained full professional proficiency or who is completely fluent as a native speaker in one language other than English;

(c) Five percent to an applicant with two or more years of professional experience or volunteer experience in the Peace Corps, AmeriCorps, domestic violence counseling, mental or behavioral health care, homelessness programs, or other social services professions; and

(d) Five percent to an applicant who has obtained an associate of arts or science degree or higher degree.

(2) The preference granted under this section may not be aggregated to exceed more than 15 percent of the applicant's examination score, shall be added to the passing mark, grade, or rating of competitive examinations until the applicant's first appointment, and may not be used in promotional examinations.

(3) For purposes of this section "full professional fluency" and "native speaker" have the same meaning as in RCW 41.04.012.

AMENDATORY SECTION (Amending WSR 05-01-200, filed 12/21/04, effective 7/1/05)

WAC 357-16-125 What must be specified in the employer's certification procedure? The employer's certification procedure must:

(1) Specify how the employer determines the pool of eligible candidates to be certified to the employing official in accordance with WAC 357-16-130;

(2) Specify how the employer determines the number of names certified if the number of eligible candidates certified to the employing official is limited;

(3) Provide for veterans' preference in accordance with WAC 357-16-110;

(4) Provide for supplemental certification of affected group members in accordance with WAC 357-16-135;

(5) Require that employing officials consider all eligible candidates certified;

(6) Provide for optional consideration of employees who have completed employer-approved training programs and are determined by the employer to meet the competencies and other position requirements;

(7) For general government employers, must provide for consideration of transition pool candidates when a certified pool contains eligible candidates other than candidates from the employer's internal or

statewide layoff list or the employer's internal promotional eligibles; ((~~and~~))

(8) Address when the employer will certify qualified individuals seeking reemployment under the provisions of WAC 357-19-470; and

(9) Address when the employer will consider granting preference to eligible applicants under the provisions of WAC 357-16-113.

OTS-5418.3

NEW SECTION

WAC 357-58-197 When may an agency head consider granting preference to eligible WMS applicants in the hiring process? (1) An agency head may consider granting preference to eligible WMS applicants in the hiring process if administering an examination prior to certification for any of the following qualifications in accordance with RCW 41.04.012:

(a) Ten percent to an applicant who has obtained full professional proficiency or who is completely fluent as a native speaker in two or more languages other than English;

(b) Five percent to an applicant who has obtained full professional proficiency or who is completely fluent as a native speaker in one language other than English;

(c) Five percent to an applicant with two or more years of professional experience or volunteer experience in the Peace Corps, AmeriCorps, domestic violence counseling, mental or behavioral health care, homelessness programs, or other social services professions; and

(d) Five percent to an applicant who has obtained an associate of arts or science degree or higher degree.

(2) The preference granted under this section may not be aggregated to exceed more than 15 percent of the applicant's examination score, shall be added to the passing mark, grade, or rating of competitive examinations until the applicant's first appointment, and may not be used in promotional examinations.

(3) For purposes of this subsection "full professional fluency" and "native speaker" have the same meaning as in RCW 41.04.012.

WSR 24-18-072
PERMANENT RULES
DEPARTMENT OF HEALTH
[Filed August 29, 2024, 11:36 a.m., effective October 1, 2024]

Effective Date of Rule: October 1, 2024.

Purpose: J-1 physician visa waiver rules in chapter 246-562 WAC. The department of health (department) amended the chapter for an overall rewrite of rule language for organization, clarity, and modernization. The adopted amendments better reflect the purpose and intent of the J-1 visa waiver program and clarify the changes in physician practice and the need for physicians across Washington state.

The adopted amendments address the applicant criteria, the application review process, and the need for more available specialists waivers slots earlier in the fiscal year. The rule adoption implements a scoring methodology to allow the department to prioritize waiver placements based on physician practices, employers, and communities that are in highest need across the state. The department created two new sections in the rule adoption to include requirements for requesting letters attestation and letters of completion.

Citation of Rules Affected by this Order: New WAC 246-562-015, 246-562-095, 246-562-115, 246-562-125, 246-562-135 and 246-562-145; repealing WAC 246-562-040, 246-562-050, 246-562-075, 246-562-085, 246-562-090, 246-562-100, 246-562-130, 246-562-140, 246-562-150 and 246-562-160; and amending WAC 246-562-010, 246-562-020, 246-562-060, 246-562-070, 246-562-080, and 246-562-120.

Statutory Authority for Adoption: RCW 70.185.040.

Adopted under notice filed as WSR 24-13-113 on June 20, 2024.

Changes Other than Editing from Proposed to Adopted Version: The department clarified the definition of "direct patient care" to include illness or disability to the purpose of providing care to patients. WAC 246-562-010(4): "Direct patient care" means providing care to patients for the purpose of prevention, diagnosis, treatment, and monitoring of disease, illness, or disability.

The department has added the original definition of "integrated health care system" back into the adopted rule to provide an understanding of the term and reduce confusion. This changed the numbering of definitions in the section.

WAC 246-562-010 (10)(a)(b): "Integrated health care system" means an organized system in which more than one health care entity participates, and in which the participating entities:

(a) Hold themselves out to the public as participating in a joint arrangement; and

(b) Participate in joint payment activity, such as clinics where a physician group charges a professional fee and a hospital charges a facility fee.

The department clarified the requirement for an unrestricted medical license in two different sections of the adopted rule to reflect the intent to require an active license without restrictions due to disciplinary action.

WAC 246-562-080(7): The physician must have an active ~~and unrestricted~~ medical license under chapter 18.71 or 18.57 RCW without any pending enforcement action cases and without any restrictions due to disciplinary action or unprofessional conduct.

WAC 246-562-135(3): The physician named in the request must have an active ~~and unrestricted~~ medical license under chapter 18.71 or 18.57 RCW without any pending enforcement action cases and without any

restrictions due to disciplinary action or unprofessional conduct to receive a letter of attestation from the department.

The department removed the time frame to make additional criteria publicly available to allow the department flexibility to share and identify criteria before the application review period.

WAC 246-562-115(7): In the event the department identifies any additional criteria, this criteria will be made publicly available ~~at least 90 days~~ prior to the applicable application review period.

The department identified a listing in department decision that was not relevant to the section it was in and removed it.

WAC 246-562-120 (2)(h): (2) The department may deny a visa waiver request or, prior to U.S. Department of State approval, may withdraw a visa waiver recommendation for cause, when the department finds the applicant has engaged in conduct contrary to the intent of the J-1 visa waiver program identified in WAC 246-562-015 including, but not limited to, the following: […]

(f) Misrepresentation; ((~~or~~))

(g) Violation of Washington state laws and rules related to charity care~~; or~~.

~~(h) Status of medical license.~~

The department clarified the requirements for an active medical license for letters of attestation requests to align with the requirements of the J-1 visa waiver program.

WAC 246-562-135(3): The physician named in the request must have an active medical license under chapter 18.71 or 18.57 RCW without any pending enforcement action cases without any restrictions due to disciplinary action or unprofessional conduct to receive a letter of attestation from the department. The physician named in the request for an attestation letter for the United States Department of Health and Human Services Waiver Program may substitute a copy of the license application and request an exception if the application was submitted to the Washington medical commission or Washington state board of osteopathic medicine and surgery prior to submission of the request for the attestation letter.

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

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

Number of Sections Adopted on the Agency's own Initiative: New 6, Amended 6, Repealed 10.

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

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 6, Amended 6, Repealed 10.

Date Adopted: August 29, 2024.

Kristin Peterson, JD
Chief of Policy
for Umair A. Shah, MD, MPH
Secretary

OTS-5475.4

AMENDATORY SECTION (Amending WSR 16-17-060, filed 8/12/16, effective 10/1/16)

WAC 246-562-010 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise:

(1) "Applicant" means an entity with an active Washington state business license, physically located in Washington state, that ((~~provides~~)) has provided health care services for a minimum of 12 months and seeks to employ a physician at a Washington state practice location(s) and is requesting ((~~state sponsorship or concurrence of a~~)) the department to provide a favorable recommendation to accompany their J-1 visa waiver application.

(2) "Board eligible" means having satisfied the requirements necessary to sit for board examinations.

(3) "Department" means the Washington state department of health.

(4) "Direct patient care" means providing care to patients for the purpose of prevention, diagnosis, treatment, and monitoring of disease, illness, or disability.

(5) "Employment contract" means a legally binding agreement between the applicant and the physician named in the visa waiver application that contains all terms and conditions of employment including, but not limited to, the salary, benefits, length of employment and any other consideration owing under the agreement.

((~~(5) "Full time"~~)) (6) "Flex waiver" means a ((~~minimum forty~~)) waiver sponsorship for a physician who will practice medicine at a location outside a designated HPSA that serves significant numbers or percentages of patients who reside in designated HPSAs.

(7) "Full-time" means the equivalent of 40 hours of medical practice per week, or 160 hours per month, not including call coverage, consisting of at least ((~~thirty-two~~)) 32 hours ((~~seeing patients~~)) providing direct patient care on an ambulatory or in-patient basis and may include up to eight hours administrative work for at least ((~~forty-eight~~)) 48 weeks per year.

((~~(6)~~)) (8) "Health professional shortage area" or "HPSA" means an area federally designated as having a shortage of primary care physicians or mental health ((~~care~~)) providers.

((~~(7)~~)) (9) "Hospitalist" means a physician((~~, usually an internist,~~)) who specializes in the care of hospitalized patients.

((~~(8)~~)) (10) "Integrated health care system (system)" means an organized system in which more than one health care entity participates, and in which the participating entities:

(a) Hold themselves out to the public as participating in a joint arrangement; and

(b) Participate in joint payment activities, such as clinics where a physician group charges a professional fee and a hospital charges a facility fee.

((~~(9)~~)) (11) "J-1 visa waiver program" or "program" refers to the department program that coordinates and sponsors J-1 visa waivers.

(12) "Low income" means ((~~that a family's~~)) a total family household income that is less than ((~~two hundred~~)) 200 percent of the federal poverty level as defined by the ((~~*U.S. Federal Poverty Guidelines* published annually~~)) annual federal poverty guidelines.

((~~(10)~~)) (13) "Physician" means the foreign physician eligible to be licensed under chapter 18.71 or 18.57 RCW named in the visa waiver application, who requires a waiver to remain in the United States to practice medicine.

((~~(11)~~)) (14) "Practice location" means the physical location(s) where the visa waiver physician will work.

((~~(12)~~)) (15) "Primary care physician" means a physician board certified or board eligible in family practice, general internal medicine, pediatrics, obstetrics/gynecology, geriatric medicine, or psychiatry. Physicians who have completed ((~~any~~)) subspecialty or fellowship training, excluding ((~~OB~~)) obstetrics or geriatric training, are not considered primary care physicians for the purpose of this chapter.

((~~(13)~~)) (16) "Publicly funded employers" means organizations such as public hospital districts, community health centers, local, state, or federal governmental institutions or correctional facilities, who have an obligation to provide care to underserved populations.

((~~(14)~~)) (17) "Sliding fee discount schedule" means a written delineation documenting the value of charge discounts granted to patients based upon patients with family income up to ((~~two hundred~~)) 300 percent of the annual federal poverty guidelines.

((~~(15)~~)) (18) "Specialist" means a physician board certified or board eligible in a specialty other than family practice, general internal medicine, pediatrics, obstetrics/gynecology, geriatric medicine, or psychiatry ((~~(~~)) who do not meet the ((~~current~~)) definition of "primary care((~~" for the waiver program)~~)) physician" as defined above.

((~~(16)~~)) (19) "Sponsorship" means a request by the department on behalf of an applicant to federal immigration authorities to grant a J-1 visa waiver for the purpose of recruiting and retaining physicians.

((~~(17)~~)) (20) "Telehealth" means a mode of delivering health care services using telecommunications technologies by a practitioner to a patient at a different physical location than the practitioner. Telehealth includes real-time interactive health care services and remote monitoring.

(21) "Vacancy" means a full-time physician practice opportunity that is based on a long-standing opening, a planned retirement, a loss of an existing physician, or an expansion of physician services in the service area.

((~~(18)~~)) (22) "Visa waiver" means a federal action that waives the requirement for a foreign physician, in the United States on a J-1 visa, to return to his/her home country for a two-year period following medical residency or fellowship training.

NEW SECTION

WAC 246-562-015 Intent of the visa waiver program. (1) The purpose of the J-1 visa waiver program is:

(a) To increase access to physicians for low income, medicaid-covered and otherwise medically underserved individuals;

(b) To increase the availability of physician services in existing federally designated HPSA for applicants that have long standing vacancies;

(c) To improve access to physician services for communities and specific underserved populations experiencing difficulties obtaining physician services; and

(d) To serve Washington communities that have identified a physician currently holding a J-1 visa as an ideal candidate to meet the community's need for health care services.

(2) The visa waiver program is intended as a secondary source for recruiting qualified physicians and is not intended as a substitute for recruiting graduates from U.S. medical schools.

(3) Sponsorship may be offered to applicants that can provide evidence of sustained active recruitment for the vacancy in the practice location for a physician who has specific needed skills, consistent with the rules established in this chapter.

(4) Sponsorship is intended to support introduction of physicians into practice settings that promote continuation of the practice beyond the initial contract period.

(5) The J-1 visa waiver program will be used to assist applicants that provide care to all residents of the federally designated HPSA. When a HPSA designation is for a population group as approved by the federal Health Research and Services Administration as defined by 42 C.F.R. Part 5, Appendices A or C, the applicant must provide care to the population group.

AMENDATORY SECTION (Amending WSR 16-17-060, filed 8/12/16, effective 10/1/16)

WAC 246-562-020 Authority to sponsor visa waivers. (1) The department may assist communities to recruit and retain physicians, or other health care professionals, as directed in chapter 70.185 RCW, ((~~by exercising an option provided in federal law. This option allows the department to sponsor a limited number of visa waivers~~)) and as provided in 22 C.F.R. Sec. 41.63 by sponsoring up to the number of allowable visa waivers as authorized by the federal government each federal fiscal year if certain conditions are met.

(2) ((~~The department may acknowledge and support as needed sponsorship proposed by federal agencies, including the United States Department of Health and Human Services.~~

~~(3) The department may carry out a visa waiver program, or, in the event of resource limitations or other considerations, may discontinue the program. Purposes of the program are:~~

~~(a) To increase the availability of physician services in existing federally designated health professional shortage areas (HPSA) for applicants that have long standing vacancies;~~

~~(b) To improve access to physician services for communities and specific underserved populations that are having difficulty finding physician services;~~

~~(c) To serve Washington communities that have identified a physician currently holding a J-1 visa as an ideal candidate to meet the community's need for health care services.~~

~~(4) The department may only sponsor a~~)) Federal law allows states to sponsor a limited number of Flex waivers.

(3) The department may provide letters of attestation for visa waiver applications sponsored by federal agencies, including the United States Department of Health and Human Services, and the Physician National Interest Waiver program.

(4) The department may exercise its discretion to sponsor a J-1 visa waiver request only when:

(a) The ((~~application contains~~)) applicant provides all of the required information and documentation on the department application and provides all supporting documents as required in this chapter; and

(b) ((~~The application~~)) When the applicant meets the criteria contained in this chapter((~~;~~

~~(c) For applicants that have benefited from department sponsorship previously,~~)).

(5) In the event an applicant has previously participated in the J-1 visa waiver program, the department may consider the applicant's history of compliance ((~~will be a consideration in future sponsorship decisions.~~

~~(5) Prior to submission of an application, the department may provide information on preparing a complete application~~)) with program rules and regulations.

(6) In any single federal fiscal year, the department ((~~will~~)) may limit the number of sponsorships granted to each ((~~applicant. Applicants, including integrated health care systems, in a single HPSA:~~

~~(a) Will not be allotted more than two sponsorships per practice location;~~

~~(b) Will not be allotted more than one hospitalist sponsorship per hospital;~~

~~(c) Will not be allotted more than three sponsorships total across all practice locations in the HPSA between October 1st and May 31st of the federal fiscal year.~~

~~(7) Applicants located outside designated HPSAs will be allotted no more than three sponsorships across all practice locations in a single county.~~

~~(8) Between October 1st and March 31st of the federal fiscal year the department will grant not more than ten specialist waivers. Any waiver sponsorships that remain unfilled on April 1st of each federal fiscal year will be available to both primary care and specialist physicians consistent with the provisions of this chapter.~~

~~(9) Starting January 15th of each federal fiscal year, the department will consider applications for physicians intending to practice in areas without a HPSA designation for applicants that meet the criteria in WAC 246-562-075.~~

~~(10) Starting June 1st of each federal fiscal year, the department will consider applications for additional sponsorships from applicants who have already received their maximum three waivers in a single HPSA~~)) location and applicant.

(7) In the event of resource limitations or other considerations, the department may choose to discontinue the program.

((~~Type of sponsorship~~	~~Application timeline and conditions~~
~~Primary care in HPSA~~	~~Available starting Oct. 1 until state reaches annual federal cap~~
~~Specialist in HPSA~~	~~Limited to 10 sponsorships from Oct. 1 - March 31, no restriction starting April 1 until state reaches annual federal cap~~
~~Nondesignated area (FLEX waiver)~~	~~Available starting Jan. 15, limited to 10 total in a federal fiscal year~~

((~~Type of sponsorship~~	~~Application timeline and conditions~~
~~More than 3 waivers for a single applicant in a single HPSA~~	~~Available starting June 1 until state reaches annual federal cap~~))

AMENDATORY SECTION (Amending WSR 16-17-060, filed 8/12/16, effective 10/1/16)

WAC 246-562-060 Criteria for applicants. (1) Applicants ((~~must:~~
~~(a) Be licensed to do business in Washington state; and~~
~~(b) Have provided medical care in Washington state for a minimum of twelve months prior to submitting the application.~~
~~(2) Applicants may be for-profit, nonprofit, or government organizations.~~
~~(3)~~)) and physicians must meet all federal criteria for international medical graduates seeking a visa waiver including the criteria established in 8 U.S.C. Sec. 1182(e), 8 U.S.C Sec. 1184(1), and 22 C.F.R. Sec. 41.63(e).

(2) Except for state psychiatric or correctional facilities, the applicant must:

(a) Currently serve:

(i) Medicare clients;

(ii) Medicaid clients;

(iii) Low-income clients; and

(iv) Uninsured clients((~~; and~~
~~(v) The population of the federal designation, if applicable~~)).

(b) Accept all patients regardless of the ability to pay.

(c) Demonstrate that during the ((~~twelve~~)) 12 months prior to submitting the application, the practice location(s) where the physician will work provided a minimum of ((~~fifteen~~)) 15 percent of total patient visits to medicaid and other low-income clients. Clients dually ((~~eligible~~)) enrolled for medicare and medicaid may be included in this total.

((~~(c) Have or agree to~~)) (d) Implement and maintain a sliding fee discount schedule for ((~~the~~)) each practice location(s) in which the J-1 visa waiver ((~~application~~)) physician will work. The schedule must be:

(i) Available in ((~~the client's principal~~)) any language ((~~and English~~)) spoken by more than 10 percent of the population in the practice location's service area;

(ii) Posted ((~~conspicuously~~)) or prominently displayed within public areas of the practice location(s);

(iii) Distributed in hard copy upon patient request; and

(iv) Updated annually to reflect the most recent federal poverty guidelines.

(3) If the applicant does not charge patients, then subsection (2)(d) of this section does not apply.

(4) Applicants must ((~~provide documentation demonstrating that the employer made a good faith effort to recruit a qualified graduate of a United States medical school for a physician vacancy in the same salary range.~~
~~(a)~~)) demonstrate that they engaged in active recruitment, specific to the location and physician specialty, ((~~must be for a period of not less than~~)) a total or aggregate of at least six months in the

((~~twelve months~~)) 12-month period immediately prior to signing an employment contract with the J-1 visa waiver physician. ((~~Active recruitment documentation can include one or more of the following:~~

~~(i) Listings in national publications;~~

~~(ii) Web-based advertisements;~~

~~(iii) Contractual agreement with a recruiter or recruitment firm; or~~

~~(iv) Listing the position with the department recruitment and retention program.~~

~~(b) In-house job postings and word-of-mouth recruitment are not considered active recruitment for the purpose of the J-1 physician visa waiver program.~~))

(5) Applicants must have a signed employment contract with the physician((~~. The employment contract must:~~

~~(a) Meet~~)) that meets state and federal requirements throughout the period of obligation, regardless of physician's visa status((~~;~~

~~(b)~~)). The employment contract must:

(a) Identify the physician's name.

(b) Identify the name and address of the proposed practice location(s).

(c) Identify the nature of services to be provided by the physician.

(d) Describe duties to be provided by the physician.

(e) Specify the wages, working conditions, and benefits.

(f) Include a statement of the federal HPSA to be served.

(g) Specify a minimum three-year period of full-time employment.

(h) State that the physician agrees to begin employment within 90 days of visa waiver approval.

(i) Not prevent the physician from providing medical services in the designated HPSA after the term of employment including, but not limited to, noncompetition clauses((~~; and~~

~~(c) Specify the three year period of employment.~~

~~(6) Any amendments made to the required elements of the employment contract under subsection (5) of this section during the first three years of contracted employment must be reported to the department for review and approval. The department will complete review and approval of such amendments within thirty calendar days of receipt~~)).

(j) State that the physician:

(i) Will provide care to medicaid, medicare, and other low-income patients;

(ii) Must see all patients regardless of ability to pay based on sliding fee scale; and

(iii) Meets all requirements set forth in 8 C.F.R. Sec. 214.1 of the Immigration Nationality Act.

((~~(7)~~)) (6) Applicants must pay the physician at least the required wage rate as referenced by the federal Department of Labor at 20 C.F.R. Sec. 655.731(a) for the specialty in the area or as set by negotiated union contract.

((~~(8)~~)) (7) If the applicant has previously requested sponsorship of a physician, WAC 246-562-020 ((~~(4)(c)~~)) (5) will apply.

((~~(9) Applicants must submit status reports to the department every twelve months, with required supporting documentation, during the initial term of employment.~~

~~(10) Physicians with a J-1 visa waiver must submit annual surveys to the department during their obligation period and a final survey one year after they complete their obligation so that the department can evaluate physician retention.~~

~~(11)~~)) (8) Applicants must cooperate in providing the department with clarifying information, verifying information already provided, or in any investigation of the applicant's financial status.

(9) Applications for a specialist physician must include a letter from the applicant. The letter must:

(a) Be on the organization's letterhead;

(b) Identify the physician by name;

(c) Demonstrate a need for the nonprimary care specialty by using available data to show how the physician specialty is needed to address a major health problem in the practice location service area, address a population to provider ratio imbalance, or meet government requirements such as trauma designation regulations;

(d) Describe how this specialty will link patients to primary care physicians;

(e) Describe how the demand for the specialty has been handled in the past;

(f) Be signed and dated by the head of the organization; and

(g) Describe the practice location's referral system that includes:

(i) On-call sharing; and

(ii) How patients from other health care entities in the service area, specifically publicly funded employers, will be able to access the sponsored physician's services.

(10) Applicants applying for a specialist physician must provide written notice to the department and all publicly funded employers in the applicant's HPSA within 30 days of the sponsored physician's start-date of employment. The notice must include:

(a) The employer and physician's name, employment start date, and practice location;

(b) Specialty and services to be provided; and

(c) Identification of accepted patients, such as medicaid, medicare, and the availability of a sliding fee schedule.

AMENDATORY SECTION (Amending WSR 16-17-060, filed 8/12/16, effective 10/1/16)

WAC 246-562-070 Criteria for ((~~the proposed~~)) practice locations ((~~to be served by the physician~~)). (1) ((~~The~~)) All proposed practice location(s) must be an existing practice location in Washington state for at least 12 months prior to application submittal.

(2) All proposed practice location(s) provided in the application will be counted toward the maximum number of sponsorships allotted as described in WAC 246-562-095 (6)(a).

(3) Any proposed practice location(s) must be located in:

(a) A federally designated primary care HPSA(s) in Washington state; or

(b) A federally designated mental health HPSA(s) in Washington state for psychiatrists((~~; or~~

~~(c) A state operated psychiatric or correctional facility.~~

~~(2) If the federal designation is based on a specific population, the applicant must serve the designated population~~)) applications.

((~~(3)~~)) (4) Local, state, or federal institutions that are federally designated with a facility designation may request state sponsorship. Physician services may be limited to the population of the institution. All other state and federal requirements must be met.

(5) If the practice location is not located in a federally designated HPSA or a state correctional or psychiatric institution, then the applicant must ((~~meet the criteria in WAC 246-562-075.~~

~~(4) The practice location named in the visa waiver application may be an existing practice location or a new practice location. If a new practice location is planned, the additional criteria in (a) through (c) of this subsection apply. New practice locations must:~~

~~(a) Have the legal, financial, and organizational structure necessary to provide a stable practice environment, and must provide a business plan that supports this information;~~

~~(b) Support a full-time physician practice;~~

~~(c) Have written referral plans that describe how patients using the new location will be connected to other care if needed~~)) apply for a Flex waiver.

(6) Successful Flex waiver applicants must be able to document:

(a) Their practice location's service area and to what extent they provide services to residents of surrounding designated HPSAs;

(b) The percentage of the sponsored physician's patient panel reasonably expected to be medicaid and medicare patients given current use of the service and practice location by those populations;

(c) How the applicant will ensure access to this physician for low-income or uninsured patients;

(d) If there is a unique practice area or substantial referral network making the physician a statewide resource for certain medical conditions; and

(e) If the physician has language skills that will benefit patients at the practice location.

AMENDATORY SECTION (Amending WSR 16-17-060, filed 8/12/16, effective 10/1/16)

WAC 246-562-080 Criteria for ((~~the~~)) physician. (1) The physician seeking a recommendation for a J-1 visa waiver from Washington state must not have a J-1 visa waiver application pending for any other employment offer((~~. The physician~~)) and must provide a letter attesting that no other applications are pending.

(2) The physician must have the qualifications described in recruitment efforts for ((~~a~~)) the specific vacancy.

(3) The physician is considered eligible to apply for a waiver when:

(a) The physician has successfully completed a residency or fellowship program; or

(b) The physician is in the final year of a residency or fellowship program, and the physician provides a letter from their training program that:

(i) Is on the program's letterhead;

(ii) Identifies the date the physician will complete the residency or fellowship program; ((~~and~~

~~(ii)~~)) (iii) Confirms the physician is in good standing with the program;

(iv) Is signed and dated by the head of the program; and

(v) Includes contact information for signee.

(4) The physician must provide full-time direct patient care.

(5) The physician must comply with all provisions of the employment contract set out in WAC 246-562-060.

(6) The physician must:

(a) Accept medicaid assignment; post and implement a sliding fee discount schedule; serve the low-income population; serve the uninsured population; and serve the HPSA designation population; or

(b) Serve the population of a local, state, or federal governmental psychiatric or corrections facility as an employee of the institution.

(7) The physician must have an active medical license under chapter 18.71 or 18.57 RCW without any pending enforcement action cases and without any restrictions due to disciplinary action or unprofessional conduct. The applicant may substitute a copy of the license application and request an exception if the application was submitted to the Washington ((~~state~~)) medical ((~~quality assurance~~)) commission or Washington state board of osteopathic medicine and surgery ((~~four or more weeks~~)) prior to submission of the visa waiver application.

(8) The physician must be an active candidate for board certification on or before the start date of employment.

(9) The physician must provide the following documentation:

(a) A current Curriculum Vitae;

(b) U.S. Department of State Data Sheet, Form DS-3035;

(c) All U.S. Department of State DS-2019 Forms (Certificate of Exchange visitor status);

(d) A physician attestation statement described in subsection (1) of this section;

(e) A no objection statement or statement that the physician is not contractually obligated to return to their home country;

(f) A personal statement from the physician regarding the reason for requesting a waiver;

(g) All U.S. Citizenship and Immigration Services (USCIS) I-94 Entry and Departure cards; and

(h) USCIS Form G-28 Notice of Entry of Appearance from an attorney, when applicable.

(10) The statements required in subsection (9)(e) and (f) of this ((~~subsection~~)) section may be on a form provided by the department or other format that provides ((~~substantially~~)) the same information as the department form.

(11) Physicians who have completed additional subspecialty training are not eligible for a primary care waiver, except for geriatric medicine, obstetrics, and psychiatry. Continuing medical education (CME) will not be considered subspecialty training for the purposes of this rule.

NEW SECTION

WAC 246-562-095 Application submittal. (1) Notwithstanding any other provisions of this chapter, this rule governs the allocation of departmental J-1 visa waiver sponsorships of specialists and primary care physicians during the federal fiscal year, which begins on October 1st of each year.

(2) The department will accept complete applications during an application review period of October 1st through October 15th of each year.

(3) The department may open an additional application review period from November 15th through September 1st if waiver slots are available.

(4) The application review period will be announced on the department's website at least 10 business days prior to the start date of the application review period.

(5) Flex waiver applications will only be received beginning January 1st of each year if waiver slots are available.

(6) From October 1st through October 15th of each year, applicants will not be allotted more than:

(a) Two sponsorships per practice location(s); and

(b) Three waiver sponsorships, including integrated health care systems.

(7) The primary application package must be submitted electronically to the department. Instructions on how to submit electronic applications will be available on the department's website.

(8) A secondary application package must be mailed or sent by commercial carrier, as long as the U.S. Department of State requires a paper application. The mailing address will be available on the department's website.

(9) Applications must be completed, meet all state and federal requirements, and must include all required documents as specified in the department application form. Application forms will be available on the department's website.

NEW SECTION

WAC 246-562-115 Application review process. (1) During the application review period of October 1st through October 15th, the following review process will apply.

(a) Applications that are ineligible or incomplete will be returned to the applicant and will not be considered for scoring. The applicant is solely responsible for ensuring that their application is complete to avoid the possibility of denial.

(b) Complete and eligible applications will undergo a full review and will be scored using the weighted scoring method posted on the department's website.

(2) Applications received during the potential review period of November 15th through September 1st will be reviewed on a first-come, first-served basis and will not undergo scoring.

(3) The department may request additional clarifying information or verify information presented in the application and may consider information outside of the submitted application during the review and scoring process.

(4) The department will use the following criteria to score and prioritize applications:

(a) Geographic location;

(b) Facility type;

(c) Specialty type;

(d) Percentage of medicaid and other low-income patients served; and

(e) HPSA designation score.

(5) The department will publish a publicly available scoring rubric each year identifying how the criteria outlined in subsection (4) of this section will be weighted.

(6) In the event the department identifies a further need for specific physician services consistent with the intent of this chap-

ter, the department may identify additional criteria or factors by which to score applications.

(7) In the event the department identifies any additional criteria, this criteria will be made publicly available prior to the applicable application review period.

(8) Sponsorships will be provided to applicants according to score.

(9) If applications receive the same score for the last available waiver slot, the applications will be reevaluated based on the scoring criteria described in subsection (4) of this section. If they still receive the same score, priority will be given in the following order:

(a) Highest percentage of medicaid and other low-income patients served;

(b) Highest HPSA designation score; and

(c) Physicians that trained or completed their residency or fellowship training in Washington state.

(10) If, after the reevaluation in subsection (9) of this section, there are applications that have equal scores for the last available waiver, the secretary of health, or the secretary's designee, will select the final applicant(s).

AMENDATORY SECTION (Amending WSR 16-17-060, filed 8/12/16, effective 10/1/16)

WAC 246-562-120 Department ((~~review and action~~)) decision. (1) ((~~The department will review applications for completeness in the date order received.~~

~~(2) Applications must be mailed, sent by commercial carrier, or delivered in person as long as the U.S. Department of State requires a paper application.~~

~~(3) The department may limit the time period during which applications may be submitted including cutting off applications after the state has sponsored all applications allowed in a given federal fiscal year.~~

~~(4) If the department receives more complete applications than the number of available waiver slots, priority will be given in the following order:~~

~~(a) Applications submitted by state psychiatric or correctional facilities;~~

~~(b) Applications for physicians working in outpatient primary care practice locations that:~~

~~(i) Are located in a HPSA;~~

~~(ii) Serve the highest percentage of medicaid and other low-income patients; and~~

~~(iii) Are not eligible for another visa waiver program.~~

~~(c) Applications for physicians working in outpatient specialty care practice locations that:~~

~~(i) Are located in a HPSA; and~~

~~(ii) Serve the highest percentage of medicaid and other low-income patients.~~

~~(5) The department will review applications within ten working days of receipt of the application to determine if the application is complete.~~

~~(6) The department will notify the applicant if the application is incomplete and will provide an explanation of what items are missing.~~

~~(7) Applicants with incomplete applications can submit additional documentation; however, the application will not be considered for approval until missing items are received and the application will not retain the date order.~~

~~(8) The department will return applications that are received after the maximum number of sponsorships have been approved. This does not apply to copies of other federal visa wavier applications.~~

~~(9) If an applicant who has already received three sponsorships submits additional applications before June 1st, the department will return the applications. Starting on June 1st these additional applications will be accepted for consideration if the department still has waiver sponsorships available.~~

~~(10) If the Washington state license under chapter 18.71 or 18.57 RCW is pending at the time the application is submitted to the department, the department may:~~

~~(a) Sponsor or concur;~~

~~(b) Hold the application in order received; or~~

~~(c) Return the application as incomplete.~~

~~(11) The department will review complete applications against the criteria specified in this chapter.~~

~~(12) The department may:~~

~~(a) Request additional clarifying information;~~

~~(b) Verify information presented;~~

~~(c) Investigate financial status of the applicant;~~

~~(d) Return the application as incomplete if the applicant does not supply requested clarifying information within thirty days of request. Incomplete applications must be resubmitted. Resubmitted applications will be considered new applications and will be reviewed in date order received.~~

~~(13) The department will notify the applicant in writing of action taken.~~)) Applicants will be notified of the department's decision within 30 business days of the review period's closing date. If the decision is to decline sponsorship, the department will provide an explanation of how the application scored or failed to meet the stated ((~~criterion or~~)) criteria.

((~~(14)~~)) (2) The department may deny a visa waiver request or, prior to U.S. Department of State approval, may withdraw a visa waiver recommendation for cause, when the department finds the applicant has engaged in conduct contrary to the intent of the J-1 visa waiver program identified in WAC ((~~246-562-020~~)) 246-562-015 including, but not limited to, the following:

(a) Application is not consistent with state or federal criteria;

(b) Dishonesty;

(c) Evasion or suppression of material facts in the visa waiver application or in any of its required documentation and supporting materials;

(d) Fraud;

(e) History of noncompliance for applicants who benefited from previous department sponsorship;

(f) Misrepresentation; or

(g) Violation of Washington state laws and rules related to charity care.

((~~(15) Applications denied may be resubmitted with concerns addressed. Resubmitted applications will be considered new applications and will be reviewed in date order received.~~))

(3) Applicants may be denied future participation in the state visa waiver program for noncompliance with any of the provisions of this chapter or federal labor law requirements.

(4) Any decision by an applicant or physician to contest a department decision, including a decision to deny or withdraw a visa waiver sponsorship, shall be governed by the Administrative Procedure Act (chapter 34.05 RCW), chapter 246-10 WAC, and this chapter. The burden shall be on the applicant or physician to establish that the department's decision or action was in error in all cases involving this chapter.

NEW SECTION

WAC 246-562-125 Reporting requirements. (1) The department may report to the U.S. Department of State and the United States Citizenship and Immigration Services if the applicant or physician is determined to be out of compliance with any of the provisions of this chapter.

(2) The following amendments made to the employment contract or changes to the employment conditions during the first three years of contracted employment must be reported to the department, which include:

(a) Practice location(s);

(b) Number of hours served by the physician;

(c) Duties served by the physician; or

(d) Any changes that would result in a decrease of the physician's wages.

(3) Any amendments to the employment contract or changes in employment conditions outlined in subsection (2) of this section must be submitted to the department for review within 30 calendar days after the effective date of the amendment.

(4) Applicants must submit status reports to the department every 12 months, with required supporting documentation, during the initial three-year term of employment.

(5) Physicians with a J-1 visa waiver must submit status reports to the department every 12 months, with required supporting documentation, during the initial three-year term of employment and one-year post-obligation period.

NEW SECTION

WAC 246-562-135 Requirements for letters of attestation. (1) The department may provide letters of attestation for visa waiver applications sponsored by federal agencies, including the Physician National Interest Waiver Program and the United States Department of Health and Human Services Waiver Program.

(2) Requests for a letter of attestation must be sent electronically to the department for consideration.

(3) The physician named in the request must have an active medical license under chapter 18.71 or 18.57 RCW without any pending en-

forcement action cases and without any restrictions due to disciplinary action or unprofessional conduct to receive a letter of attestation from the department. The physician named in the request for an attestation letter for the United States Department of Health and Human Services Waiver Program may substitute a copy of the license application and request an exception if the application was submitted to the Washington medical commission or Washington state board of osteopathic medicine and surgery prior to submission of the request for the attestation letter.

(4) The practice location(s) provided in the request must be located in a primary care HPSA, or a mental health HPSA for psychiatrists.

(5) Requests for a letter of attestation must include a letter from the employer. The letter from the employer must:

(a) Be on employer letterhead;

(b) Identify the waiver program;

(c) Describe how the physician's practice is in the public interest;

(d) State that the employer treats all patients regardless of their ability to pay, accepts medicare, medicaid, and S-CHIP assignment, uses a sliding fee discount, and may charge no more than the usual customary rate prevailing in the geographic area in which the services are provided; and

(e) Be signed and dated by the head of the organization.

(6) To receive a letter of attestation for a Physician National Interest Waiver application, the request must include an employment contract. The employment contract must:

(a) Include a total of five years of employment obligation;

(b) Identify the practice location(s) and HPSA identification number; and

(c) Not include a noncompete clause that prohibits the physician from providing services within the community at the end of their three-year period of obligation.

(7) If the physician received a J-1 visa waiver in Washington state, all currently due annual reports must be completed by the physician and employer prior to requesting a letter of attestation.

(8) The department may credit prior employment years served by the physician toward the five-year service obligation under the following conditions.

(a) The previous employment must not be served during fellowship or residency training.

(b) The previous employment must not be served while under J-1 visa status.

(c) The previous employment must be served in a health care facility in an area with a HPSA designation.

(9) To receive a letter of attestation for a U.S. Department of Health and Human Services waiver application, the request must be for a primary care physician and include an employment contract. The employment contract must:

(a) Include a minimum of three years employment obligation;

(b) Identify the practice location and HPSA identification number;

(c) State that the physician agrees to start employment within 90 days of receiving the waiver;

(d) Obligate the physician to work 40 hours per week providing primary care services;

(e) Include a clause that the contract can only be terminated for cause until the completion of the three-year commitment; and

(f) Not contain a noncompete clause or restrictive covenant.

(10) The physician must complete their training no more than 12 months prior to the start date of employment under a U.S. Department of Health and Human Services waiver.

NEW SECTION

WAC 246-562-145 Requirements for letters of completion. (1) The department may provide a letter of completion to confirm a physician's fulfillment of the three-year service obligation under the Washington state J-1 physician visa waiver program.

(2) Requests for a letter of completion must be sent electronically to the department for consideration.

(3) The department will consider providing a completion letter based on the following criteria:

(a) The status of an active medical license without any pending enforcement actions;

(b) If the physician and employer complied with the program rules and regulations;

(c) The completion of all annual reports under the three-year service obligation by both the employer and the physician. The submitted annual reports must verify that:

(i) The physician was not absent from the practice for more than four weeks per year;

(ii) The physician worked at least 32 hours per week providing patient care services; and

(iii) The employer had a current sliding fee discount schedule in place to reflect the most recent federal poverty guidelines.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 246-562-040	Principles that will be applied to the visa waiver program.
WAC 246-562-050	Review criteria.
WAC 246-562-075	Criteria for waiver sponsorships in nondesignated areas.
WAC 246-562-085	Eligibility for primary care and specialist waivers.
WAC 246-562-090	Application form.
WAC 246-562-100	Criteria applied to federally designated facilities.
WAC 246-562-130	Eligibility for future participation in the visa waiver program.

WSR 24-18-076
PERMANENT RULES
HEALTH CARE AUTHORITY
(Public Employees Benefits Board)
[Admin #2024-01.01—Filed August 29, 2024, 1:31 p.m., effective January 1, 2025]

Effective Date of Rule: January 1, 2025.

Purpose: The purpose of this proposal is to amend existing rules to support the public employees benefits board (PEBB) program:

1. Implement statutory changes:

- In response to implement SB 5700, section 3, chapter 51, Laws of 2023, amended WAC 182-12-111 to remove employees of the Washington state convention and trade centers and amended WAC 182-16-2050 to update the flexible spending arrangement (FSA) description.

2. Make technical amendments:

- Amended WAC 182-08-120 to include vision insurance.
- Amended WAC 182-08-185 to include an enrollee who elects to continue medical coverage in WAC 182-12-232 must provide an attestation on the required form and clarified a subscriber must provide evidence of the event when there is a change in the spouse's or state registered domestic partner's employer-based group medical.
- Amended WAC 182-08-191 to update who must provide the PEBB program with their correct address and updates to their address if it changes.
- Amended WAC 182-08-235 to remove board of directors for school districts and educational service districts, clarified this section applies to employer groups for the PEBB program, and updated subsection references.
- Amended WAC 182-12-111 to clarify employer groups for the PEBB program, removed board of directors for school districts and educational service districts, added PEBB vision, and updated subsection references.
- Amended WAC 182-12-114 and 182-12-136 to include PEBB vision.
- Amended WAC 182-12-133, 182-12-142, and 182-12-270 to include PEBB vision and added an exception to employees who are not subject to the first premium payment and application premium surcharges.
- Amended WAC 182-12-263 to update who must submit the required forms to the PEBB program, updated subsection references, and clarified when the changes to the health plan coverage or enrollment will begin following the receipt of NMSN.
- Amended WAC 182-16-2010 to clarify PEBB participating employer group and to add PEBB vision.
- Amended WAC 182-16-2030 to clarify PEBB participating employer group and to update a list of applicable appellants regarding when their request for a brief adjudicative proceeding must be received by the PEBB appeals unit.
- Amended WAC 182-16-2040 to update a list of applicable appellants regarding when their request for a brief adjudicative proceeding must be received by the PEBB appeals unit.
- Amended WAC 182-16-2060 to clarify this section applies to an entity or organization whose employer group application is to participate in PEBB insurance coverage.

3. Improve the administration of the PEBB program:

- Amended WAC 182-12-116 to clarify employees of PEBB participating employer groups.
- Amended WAC 182-12-131 to add a new subsection for clarity.

Citation of Rules Affected by this Order: Amending WAC 182-08-120, 182-08-185, 182-08-191, 182-08-235, 182-12-111, 182-12-114, 182-12-116, 182-12-131, 182-12-133, 182-12-136, 182-12-141, 182-12-142, 182-12-148, 182-12-263, 182-12-270, 182-16-2010, 182-16-2030, 182-16-2040, 182-16-2050, and 182-16-2060.

Statutory Authority for Adoption: RCW 41.05.021, 41.06.065 [41.05.065], and 41.05.160.

Other Authority: PEBB resolutions.

Adopted under notice filed as WSR 24-14-124 on July 2, 2024.

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

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

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 17, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 18, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 18, Repealed 0.

Date Adopted: August 29, 2024.

Wendy Barcus
Rules Coordinator

OTS-5519.1

AMENDATORY SECTION (Amending WSR 21-13-106, filed 6/18/21, effective 1/1/22)

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 employer-paid long-term disability (LTD) insurance benefit, medical insurance, dental insurance, vision 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 21-13-106, filed 6/18/21, effective 1/1/22)

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~~)) 13 years and older, engages in tobacco use.

(a) A subscriber must attest to whether any enrollee, ((~~thirteen~~)) 13 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~~)) 13 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~~)) 13 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~~)) 13 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, or 182-12-232 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) 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~~)) 13 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~~)) 18 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~~)) 13 through ((~~seventeen~~)) 17 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~~)) 95 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~~)) 95 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~~)) 95 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~~)) 95 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 provide evidence of the event and update their attestation on the required form. An employee must submit the form to their employing agency no later than ((~~sixty~~)) 60 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~~)) 60 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 182-08-191 Subscriber address requirements. (1) All employees must provide their employing agency with their correct address and update their address if it changes. ((~~A subscriber on public employees benefits board (PEBB) retiree insurance coverage, or continuation coverage~~)) All other subscribers must provide the PEBB program with their correct address and updates to their address if it changes.

(2) In the event of an appeal, appellants must update their address as required in WAC 182-16-055.

AMENDATORY SECTION (Amending WSR 23-14-015, filed 6/23/23, effective 1/1/24)

WAC 182-08-235 Employer group ((~~and board of directors for school districts and educational service districts~~)) application process. This section applies to employer groups for the public employees benefits board (PEBB) program as defined in WAC 182-08-015 ((~~and board members of school districts and educational service districts~~)). An employer group ((~~or board member of a school district or an educational service district~~)) may apply to obtain ((~~public employees benefits board (PEBB)~~)) PEBB insurance coverage through a contract with the health care authority (HCA).

(1) Employer groups with less than 500 employees ((~~and board members of school districts and educational service districts~~)) must apply at least 60 days before the requested coverage effective date. Employer groups with 500 or more employees but with less than 5,000 employees must apply at least 90 days before the requested effective date.

Employer groups with 5,000 or more employees must apply at least 120 days before the requested coverage effective date.

To apply, employer groups must submit the documents and information described in subsection (2) of this section to the PEBB program as follows:

(a) ((~~Board members of school districts and educational service districts are required to provide the documents described in subsection (2)(a) through (c) of this section;~~

~~(b)~~)) Counties, municipalities, political subdivisions, and tribal governments with fewer than 5,000 employees are required to provide the documents and information described in subsection (2)(a) through (f) of this section;

((~~(c)~~)) (b) Counties, municipalities, political subdivisions, and tribal governments with 5,000 or more employees will have their application approved or denied through the evaluation criteria described in WAC 182-08-240 and are required to provide the documents and information described in subsection (2)(a) through (d), (f), and (g) of this section; and

((~~(d)~~)) (c) All employee organizations representing state civil services employees and the Washington health benefit exchange, regardless of the number of employees, will have their application approved or denied through the evaluation criteria described in WAC 182-08-240 and are required to provide the documents and information described in subsection (2)(a) through (d), (f), and (g) of this section.

(2) Documents and information required with application:

(a) A letter of application that includes the information described in (a)(i) through (iv) of this subsection:

(i) A reference to the group's authorizing statute;

(ii) A description of the organizational structure of the group and a description of the employee bargaining unit or group of nonrepresented employees for which the group is applying;

(iii) Tax identification number; and

(iv) A statement of whether the group is applying to obtain only medical or all available PEBB insurance coverages.

((~~**Note:** Boards of directors of school districts or educational service districts must provide a statement that the group is agreeing to obtain medical, dental, and life insurance.~~))

(b) A resolution from the group's governing body authorizing the purchase of PEBB insurance coverage.

(c) A signed governmental function attestation document that attests to the fact that employees for whom the group is applying are governmental employees whose services are substantially all in the performance of essential governmental functions.

(d) A member level census file for all of the employees for whom the group is applying. The file must be provided in the format required by the authority and contain the following demographic data, by member, with each member classified as employee, spouse or state registered domestic partner, or child:

(i) Employee ID (any identifier which uniquely identifies the employee; for dependents the employee's unique identifier must be used);

(ii) Age;

(iii) Birth sex;

(iv) First three digits of the member's zip code based on residence;

(v) Indicator of whether the employee is active or retired, if the group is requesting to include retirees; and

(vi) Indicator of whether the member is enrolled in coverage.

(e) Historical claims and cost information that include the following:

(i) Large claims history for 24 months by quarter that excludes the most recent three months;

(ii) Ongoing large claims management report for the most recent quarter provided in the large claims history;

(iii) Summary of historical plan costs; and

(iv) The director or the director's designee may make an exception to the claims and cost information requirements based on the size of the group, except that the current health plan does not have a case management program, then the primary diagnosis code designated by the authority must be reported for each large claimant. If the code indicates a condition which is expected to continue into the next quarter, the claim is counted as an ongoing large claim. If historical claims and cost information as described in (e)(i) through (iii) of this subsection are unavailable, the director or the director's designee may make an exception to allow all of the following alternative requirements:

• A letter from their carrier indicating they will not or cannot provide claims data.

• Provide information about the health plan most employees are enrolled in by completing the actuarial calculator authorized by the PEBB program.

• Current premiums for the health plan.

(f) If the application is for a subset of the group's employees (e.g., bargaining unit), the group must provide a member level census file of all employees eligible under their current health plan who are not included on the member level census file in (d) of this subsection. This includes retired employees participating under the group's current health plan. The file must include the same demographic data by member.

(g) Employer groups described in subsection (1)((~~(c)~~)) (b) and ((~~(d)~~)) (c) of this section must submit to an actuarial evaluation of the group provided by an actuary designated by the PEBB program. The group must pay for the cost of the evaluation. This cost is nonrefundable. A group that is approved will not have to pay for an additional actuarial evaluation if it applies to add another bargaining unit within two years of the evaluation. Employer groups of this size must provide the following:

(i) Large claims history for 24 months, by quarter that excludes the most recent three months;

(ii) Ongoing large claims management report for the most recent quarter provided in the large claims history;

(iii) Executive summary of benefits;

(iv) Summary of benefits and certificate of coverage; and

(v) Summary of historical plan costs.

Exception: If the current health plan does not have a case management program then the primary diagnosis code designated by the authority must be reported for each large claimant. If the code indicates a condition which is expected to continue into the next quarter, the claim is counted as an ongoing large claim.

(3) The authority may automatically deny a group application if the group fails to provide the required information and documents described in this section.

OTS-5523.2

AMENDATORY SECTION (Amending WSR 23-14-015, filed 6/23/23, effective 1/1/24)

WAC 182-12-111 Which entities and individuals are eligible for public employees benefits board (PEBB) benefits? The following entities and individuals shall be eligible for public employees benefits board (PEBB) benefits subject to the terms and conditions set forth below:

(1) **State agencies.** State agencies, as defined in WAC 182-12-109, are required to participate in all PEBB benefits. Insurance and health care contributions for ferry employees shall be governed by RCW 47.64.270.

(2) **Employer groups.** Employer groups as defined in WAC 182-12-109 for the PEBB program may apply to participate in PEBB insurance coverage for groups of employees described in (a)(i) of this subsection and for members of the group's governing authority as described in (a)(i), (ii), and (iii) of this subsection at the option of each employer group:

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

(i) Bargaining units may elect to participate separately from the whole group;

(ii) Nonrepresented employees may elect to participate separately from the whole group provided all nonrepresented employees join as a group; and

(iii) Members of the employer group's governing authority may participate as described in the employer group's governing statutes and RCW 41.04.205.

(b) Employer groups must apply through the process described in WAC 182-08-235. Applications from employees of employee organizations representing state civil service employees, the Washington health benefit exchange, and employer groups with 5,000 or more employees are subject to review and approval by the health care authority (HCA) based on the employer group evaluation criteria described in WAC 182-08-240.

(c) Employer groups participate through a contract with the authority as described in WAC 182-08-245.

(3) **The Washington health benefit exchange.** In addition to subsection (2) of this section, the following provisions apply:

(a) The Washington health benefit exchange is subject to the same rules as an employing agency in chapters 182-08, 182-12, and 182-16 WAC.

(b) Employees of the Washington health benefit exchange are subject to the same rules as employees of an employing agency in chapters 182-08, 182-12 and 182-16 WAC.

(4) **Eligible nonemployees.**

(a) Blind vendors actively operating a business enterprise program facility in the state of Washington and deemed eligible by the department of services for the blind (DSB) may voluntarily participate in PEBB medical. Dependents of blind vendors are eligible as described in WAC 182-12-260.

(i) Eligible blind vendors and their dependents may enroll during the following times:

• When newly eligible: The DSB will notify eligible blind vendors of their eligibility in advance of the date they are eligible for enrollment in PEBB medical.

To enroll, blind vendors must submit the required forms to the DSB. The forms must be received by the DSB no later than 31 days after the blind vendor becomes eligible for PEBB medical;

• During the annual open enrollment: Blind vendors may enroll during the annual open enrollment. The required form must be received by the DSB before the end of the annual open enrollment. Enrollment will begin January 1st of the following year; or

• Following loss of other medical insurance coverage: Blind vendors may enroll following loss of other medical insurance coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA). To enroll, blind vendors must submit the required forms to the DSB. The forms must be received by the DSB no later than 60 days after the loss of other medical insurance coverage. In addition to the required forms, the DSB will require blind vendors to provide evidence of loss of other medical insurance coverage.

(ii) Blind vendors who cease to actively operate a facility become ineligible to participate in PEBB medical as described in (a) of this subsection. Enrollees who lose eligibility for coverage may continue enrollment in PEBB medical on a self-pay basis under Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage as described in WAC 182-12-146((~~(5)~~)) (6).

(iii) Blind vendors are not eligible for PEBB retiree insurance coverage.

(b) Dislocated forest products workers enrolled in the employment and career orientation program pursuant to chapter 50.70 RCW shall be eligible for PEBB medical ((~~and~~)), dental, and vision while enrolled in that program.

((~~(c) Board members of Washington state school districts and educational service districts eligible to participate under RCW 28A.400.350 may participate in PEBB medical, dental, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, supplemental life insurance, and supplemental AD&D insurance as long as they remain eligible under that section. The board of directors of educational service districts must apply through the process described in WAC 182-08-235 and participate through a contract with the HCA as described in WAC 182-08-245. Dependents of board members are eligible as described in WAC 182-12-260.~~

~~(i) Upon contract with the HCA, eligible board members may individually decide to enroll in PEBB insurance coverage each plan year. If they elect not to enroll, they may only enroll at the following times:~~

~~• During the annual open enrollment; or~~

~~• Following loss of other medical insurance coverage as defined by the Health Insurance Portability and Accountability Act (HIPAA).~~

~~(ii) Board members who no longer hold a position become ineligible to participate in PEBB insurance coverage as described in (c) of this subsection. Enrollees who lose eligibility for coverage may continue enrollment in PEBB medical, PEBB dental, or both on a self-pay basis under COBRA coverage as described in WAC 182-12-146(6).~~

~~(iii) Board members are not eligible for PEBB retiree insurance coverage.~~))

(5) **Individuals and entities not eligible as employees include:**

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

(b) Unpaid volunteers;

(c) Patients of state hospitals;

(d) Inmates in work programs offered by the Washington state department of corrections as described in RCW 72.09.100 or an equivalent program administered by a local government;

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

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

((~~(g)~~)) (f) Any others not expressly defined as an employee.

AMENDATORY SECTION (Amending WSR 22-13-158, filed 6/21/22, effective 1/1/23)

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 80 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, vision, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, 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 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 80 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 80 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, vision, basic life insurance, basic AD&D insurance, 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 begin on the first day of the month following the date the contracted vendor receives the required form or approves the enrollment.

Exception: Seasonal employees who work a recurring, annual season with a duration of less than nine months are not eligible for the employee-paid LTD insurance benefit.

(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, vision, basic life insurance, basic AD&D insurance, 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 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, vision, basic life insurance, basic AD&D insurance, 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 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, vision, basic life insurance, basic AD&D insurance, 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 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, vision, basic life insurance, basic AD&D insurance, 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 begin on the first day of the month following the date the contracted vendor receives the required form or approves the enrollment.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-12-116 Who is eligible to participate in the salary reduction plan? (1) Employees of state agencies are eligible to participate in the state's salary reduction plan provided they are eligible for public employees benefits board (PEBB) benefits as described in WAC 182-12-114 and they elect to participate within the time frames described in WAC 182-08-197, 182-08-187, or 182-08-199.

(2) Employees of PEBB participating employer groups, as defined in WAC 182-12-109, are not eligible to participate in the state's salary reduction plan.

AMENDATORY SECTION (Amending WSR 20-16-062, filed 7/28/20, effective 1/1/21)

WAC 182-12-131 How do eligible employees maintain the employer contribution toward public employees benefits board (PEBB) benefits? The employer contribution toward public employees benefits board (PEBB) benefits begins as described in WAC 182-12-114. This section describes under what circumstances employees maintain eligibility for the employer contribution toward PEBB benefits.

(1) **Maintaining the employer contribution.** Except as described in subsections (2), (3), and (4) of this section, employees who have established eligibility for benefits as described in WAC 182-12-114 are eligible for the employer contribution each month in which they are in pay status eight or more hours per month.

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

(a) Benefits-eligible seasonal employees (eligible as described in WAC 182-12-114(2)) who work a season of less than nine months are eligible for the employer contribution in any month of the season in which they are in pay status eight or more hours during that month. The employer contribution toward PEBB benefits for seasonal employees returning after their off season begins on the first day of the first month of the season in which they are in pay status eight hours or more.

(b) Benefits-eligible seasonal employees (eligible as described in WAC 182-12-114(2)) who work a season of nine months or more are eligible for the employer contribution:

(i) In any month of the season in which they are in pay status eight or more hours during that month; and

(ii) Through the off season following each season worked, but the eligibility may not exceed a total of ((~~twelve~~)) 12 consecutive calendar months for the combined season and off season.

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

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

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

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

Exception: Eligibility for the employer contribution toward summer or off-quarter/semester PEBB benefits ends on the end date specified in an employing agency's termination notice or an employee's resignation letter, whichever is earlier, if the employing agency has no anticipation that the employee will be returning as faculty at any institution of higher education where the employee has employment. If the employing agency deducted the employee's premium for PEBB insurance coverage after the employee was no longer eligible for the employer contribution, PEBB benefits end the last day of the month for which employee premiums were deducted.

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

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

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

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

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

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

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

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

(i) Employees on authorized leave without pay;

(ii) Employees on approved educational leave;

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

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

(v) Employees applying for disability retirement.

(5) **Maintaining the employer contribution - Employees who move from an eligible to an otherwise ineligible position due to a layoff** maintain the employer contribution toward PEBB benefits as described in WAC 182-12-129.

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

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

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

(7) **The employer contribution toward PEBB benefits ends** in any one of these circumstances for all employees:

(a) When employees fail to maintain eligibility for the employer contribution as indicated in the criteria in subsections (1) through (6) of this section.

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

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

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

(c) When employees move to a position that is not anticipated to be eligible for PEBB benefits as described in WAC 182-12-114, not including changes in position due to a layoff.

(d) The employer contribution toward PEBB benefits cease for employees and their enrolled dependents the last day of the month in which employees are eligible for the employer contribution under this section.

Exception: If the employing agency deducted the employee's premium for PEBB insurance coverage after the employee was no longer eligible for the employer contribution, PEBB benefits end the last day of the month for which employee premiums were deducted.

(8) **Options for continuation coverage by self-paying.** During temporary or permanent loss of the employer contribution toward PEBB benefits, employees have options for providing continuation coverage for themselves and their dependents by self-paying the premium and applicable premium surcharges set by the health care authority (HCA). These

options are available as described in WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, and 182-12-270.

AMENDATORY SECTION (Amending WSR 21-13-103, filed 6/18/21, effective 1/1/22)

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, or vision and may also continue life insurance and accidental death and dismemberment (AD&D) insurance. If life insurance or AD&D insurance is elected, both basic life and basic AD&D insurance must be continued. 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 employer-paid long-term disability (LTD) insurance or both employer-paid and 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~~)) 60 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~~)) 29 months. The employee's first premium payment and applicable premium surcharges are due no later than ((~~forty-five~~)) 45 days after the election period ends as described in (c) of this subsection, except as described in WAC 182-08-180 (1)(a).

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, PEBB vision, 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~~)) 60 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, vision, or ((~~both~~)) any combination of these benefits 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 16-20-080, filed 10/4/16, effective 1/1/17)

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

AMENDATORY SECTION (Amending WSR 20-16-062, filed 7/28/20, effective 1/1/21)

WAC 182-12-141 If an employee reverts from an eligible position, what happens to their public employees benefits board (PEBB) insurance coverage? (1) If an employee reverts for reasons other than a layoff and is not eligible for the employer contribution toward public employees benefits board (PEBB) benefits under this chapter, they may continue PEBB insurance coverage by self-paying the premium and applicable premium surcharge set by the health care authority (HCA) for up to ((~~eighteen~~)) 18 months under the same terms as an employee who is granted leave without pay under WAC 182-12-133(1):

(a) The employee's election must be received by the PEBB program no later than ((~~sixty~~)) 60 days from the date the employee's PEBB

health plan coverage ended or from the postmark date on the election notice sent by the PEBB program, whichever is later;

(b) The employee's first premium payment and applicable premium surcharges are due to the HCA no later than ((~~forty-five~~)) 45 days after the election period ends as described in (a) of this subsection, except as described in WAC 182-08-180 (1)(a). 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 and PEBB vision. Premiums associated with continuing life insurance and accidental death and dismemberment insurance coverage must be made to the contracted vendor;

(c) Following the employee's first premium payment, the employee must pay the premium amounts associated with PEBB insurance coverage and applicable premium surcharges as premiums become due; and

(d) If the employee's monthly premium or applicable premium surcharges remain unpaid for ((~~sixty~~)) 60 days from the original due date, the employee's PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharges were paid as described in WAC 182-08-180 (1)(c).

(2) If an employee is reverted due to a layoff, the employee may be eligible for the employer contribution toward PEBB benefits under the criteria of WAC 182-12-129. If determined not to be eligible under WAC 182-12-129, the employee may continue PEBB insurance coverage by self-paying the premium and applicable premium surcharges set by the HCA under WAC 182-12-133.

AMENDATORY SECTION (Amending WSR 20-16-062, filed 7/28/20, effective 1/1/21)

WAC 182-12-142 What options for continuation coverage are available to faculty and seasonal employees who are between periods of eligibility? (1) **Faculty** may continue any combination of medical ((~~or~~)), dental, or vision, and may also continue life insurance and accidental death and dismemberment (AD&D) insurance by self-paying the premium and applicable premium surcharges set by the health care authority (HCA), with no contribution from the employer, for a maximum of ((~~twelve~~)) 12 months between periods of eligibility. If life insurance or AD&D insurance is elected, both basic life and basic AD&D insurance must be continued. Employees who continue basic life insurance and basic AD&D insurance may also continue supplemental life and AD&D insurance:

(a) The employee's election must be received by the public employees benefits board (PEBB) program no later than ((~~sixty~~)) 60 days from the date the employee's PEBB health plan coverage ended or from the postmark date on the election notice sent by the PEBB program, whichever is later;

(b) The employee's first premium payment and applicable premium surcharges are due to the HCA no later than ((~~forty-five~~)) 45 days after the election period ends as described in (a) of this subsection, except as described in WAC 182-08-180 (1)(a). 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 and PEBB vision. Premiums associated with continuing life in-

surance and AD&D insurance coverage must be made to the contracted vendor;

(c) Following the employee's first premium payment, the employee must pay the premium amounts associated with PEBB insurance coverage and applicable premium surcharges as premiums become due; and

(d) If the employee's monthly premium or applicable premium surcharges remain unpaid for ((~~sixty~~)) 60 days from the original due date, the employee's PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharges were paid as described in WAC 182-08-180 (1)(c).

(2) **Benefits-eligible seasonal employees** may continue any combination of medical ((~~or~~))**,** dental, or vision, and may also continue life insurance and AD&D insurance by self-paying the premium and applicable premium surcharges set by the HCA, with no contribution from the employer, for a maximum of ((~~twelve~~)) 12 months between periods of eligibility. If life insurance or AD&D insurance is elected, both basic life and basic AD&D insurance must be continued. Employees who continue basic life insurance and basic AD&D insurance may also continue supplemental life and AD&D insurance:

(a) The employee's election must be received by the PEBB program no later than ((~~sixty~~)) 60 days from the date the employee's PEBB health plan coverage ended or from the postmark date on the election notice sent by the PEBB program, whichever is later;

(b) The employee's first premium payment and applicable premium surcharges are due to the HCA no later than ((~~forty-five~~)) 45 days after the election period ends as described in (a) of this subsection, except as described in WAC 182-08-180 (1)(a). 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 and PEBB vision. Premiums associated with continuing life insurance and AD&D insurance coverage must be made to the contracted vendor;

(c) Following the employee's first premium payment, the employee must pay the premium amounts associated with PEBB insurance coverage and applicable premium surcharges as premiums become due; and

(d) If the employee's monthly premium or applicable premium surcharges remain unpaid for ((~~sixty~~)) 60 days from the original due date, the employee's PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharges were paid as described in WAC 182-08-180 (1)(c).

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

AMENDATORY SECTION (Amending WSR 21-13-103, filed 6/18/21, effective 1/1/22)

WAC 182-12-148 What options for continuation coverage are available to employees during their appeal of dismissal? (1) Employees awaiting the hearing outcome of a dismissal action before any of the following may continue their public employees benefits board (PEBB) insurance coverage by self-paying the premium and applicable premium surcharges set by the health care authority (HCA), with no contribution from the employer, on the same terms as an employee who is granted leave as described in WAC 182-12-133:

(a) The personnel resources board;

(b) An arbitrator;

(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~~)) 60 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 any combination of PEBB medical, dental, or ((~~both~~)) vision 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 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.

AMENDATORY SECTION (Amending WSR 22-13-158, filed 6/21/22, effective 1/1/23)

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. All other 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;

(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)((~~(g)~~)) (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 or the PEBB program 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.

AMENDATORY SECTION (Amending WSR 20-16-062, filed 7/28/20, effective 1/1/21)

WAC 182-12-270 What options for continuation coverage are available to dependents who cease to meet the eligibility criteria as described in WAC 182-12-260? If eligible, dependents may continue health plan enrollment under one of the continuation coverage options in subsection (1) or (2) of this section by self-paying the premiums and applicable premium surcharges set by the health care authority (HCA), with no contribution from the employer, following their loss of eligibility under the subscriber's health plan coverage. The dependent's first premium payment and applicable premium surcharges are due no later than ((~~forty-five~~)) 45 days after the election period ends as described in WAC 182-12-146, 182-12-180, 182-12-250, or 182-12-265, whichever applies, except as described in WAC 182-08-180 (1)(a). 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 and PEBB vision insurance coverages. Following the dependent's first premium payment, the dependent must pay premium and applicable premium surcharges as they become due. If the monthly premium or applicable premium surcharges remain unpaid for ((~~sixty~~)) 60 days from the original due date, PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharges were paid as described in WAC 182-08-180 (1)(c). The PEBB program must receive the required forms as outlined in the *PEBB Initial Notice of COBRA and Continuation Coverage Rights*. Options for continuing health plan enrollment are based on the reason that eligibility was lost.

(1) Spouses, state registered domestic partners, or children who lose eligibility due to the death of an employee or retiree may be eligible to continue health plan enrollment as described in WAC 182-12-180, 182-12-250, or 182-12-265; or

(2) Dependents who lose eligibility because they no longer meet the eligibility criteria as described in WAC 182-12-260 are eligible to continue PEBB medical, dental, vision, or ((~~both~~)) any combination of these coverages under provisions of the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). See WAC 182-12-146 for more information on COBRA.

(3) A subscriber's state registered domestic partner and the state registered domestic partner's children may continue PEBB medical, dental, vision, or ((~~both~~)) any combination of these coverages on the same terms and conditions as spouses and other eligible dependents under COBRA as described under RCW 26.60.015.

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

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AMENDATORY SECTION (Amending WSR 20-16-062, filed 7/28/20, effective 1/1/21)

WAC 182-16-2010 Appealing a decision regarding public employees benefits board (PEBB) eligibility, enrollment, premium payments, premium surcharges, a wellness incentive, or the administration of benefits. (1) Any current or former employee of a state agency or their dependent aggrieved by a decision made by the state agency with regard to public employees benefits board (PEBB) eligibility, enrollment, or premium surcharges may appeal that decision to the state agency by the process described in WAC 182-16-2020.

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

(2) Any current or former employee of ((~~an~~)) a PEBB participating employer group or their dependent who is aggrieved by a decision made by ((~~an~~)) the employer group with regard to PEBB eligibility, enrollment, or premium surcharges may appeal that decision to the employer group through the process established by the employer group.

Exception: Any current or former employee of ((~~an~~)) a PEBB participating employer group aggrieved by a decision regarding life insurance, long-term disability (LTD) insurance, eligibility to participate in the PEBB wellness incentive program, or eligibility to receive a PEBB wellness incentive may appeal that decision to the PEBB appeals unit by the process described in WAC 182-16-2030.

(3) Any subscriber or dependent aggrieved by a decision made by the PEBB program with regard to PEBB eligibility, enrollment, premium payments, premium surcharges, eligibility to participate in the PEBB wellness incentive program, or eligibility to receive a PEBB wellness incentive, may appeal that decision to the PEBB appeals unit by the process described in WAC 182-16-2030.

(4) Any enrollee aggrieved by a decision regarding the administration of PEBB medical ((~~and~~)), dental, 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.

(5) Any PEBB enrollee aggrieved by a decision regarding the administration of PEBB long-term care insurance or property and casualty insurance may appeal that decision by following the appeal provisions of those plans.

(6) Any PEBB employee aggrieved by a decision regarding the administration of a benefit offered under the salary reduction plan may appeal that decision by the process described in WAC 182-16-2050.

(7) Any subscriber aggrieved by a decision made by the PEBB wellness incentive program contracted vendor regarding the completion of the PEBB wellness incentive program requirements, or a request for a reasonable alternative to a wellness incentive program requirement, may appeal that decision by the process described in WAC 182-16-2040.

AMENDATORY SECTION (Amending WSR 20-16-062, filed 7/28/20, effective 1/1/21)

WAC 182-16-2030 Appealing a public employees benefits board (PEBB) program decision regarding eligibility, enrollment, premium

payments, premium surcharges, a PEBB wellness incentive, or certain decisions made by an employer group. (1) A decision made by the public employees benefits board (PEBB) program regarding eligibility, enrollment, premium payments, premium surcharges, or a PEBB wellness incentive, may be appealed by submitting a request to the PEBB appeals unit for a brief adjudicative proceeding to be conducted by the authority.

(2) A decision made by ((~~an~~)) a PEBB participating employer group regarding life insurance, LTD insurance, eligibility to participate in the PEBB wellness incentive program, or eligibility to receive a PEBB wellness incentive, may be appealed by submitting a request to the PEBB appeals unit for a brief adjudicative proceeding to be conducted by the authority.

(3) The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(4) The request for a brief adjudicative proceeding from a current or former employee or employee's dependent must be received by the PEBB appeals unit no later than ((~~thirty~~)) 30 days after the date of the denial notice.

(5) The request for a brief adjudicative proceeding from a retiree, ((~~self-pay~~)) a continuation coverage enrollee, a retired employee or retired school employee continuing PEBB health plan coverage when their employer group ceases participation, a survivor, or their dependent ((~~of a retiree or self-pay enrollee~~)) must be received by the PEBB appeals unit no later than ((~~sixty~~)) 60 days after the date of the denial notice.

(6) The PEBB appeals unit must notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(7) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(8) Failing to timely request a brief adjudicative proceeding will result in the prior PEBB program decision becoming the authority's final order without further action.

AMENDATORY SECTION (Amending WSR 20-16-062, filed 7/28/20, effective 1/1/21)

WAC 182-16-2040 How can a subscriber appeal a decision regarding the administration of wellness incentive program requirements? (1) Any subscriber aggrieved by a decision regarding the completion of the wellness incentive program requirements, or request for a reasonable alternative to a wellness incentive program requirement, may appeal that decision to the public employees benefits board (PEBB) wellness incentive program contracted vendor.

(2) Any subscriber who disagrees with a decision in response to an appeal filed with the PEBB wellness incentive program contracted vendor may appeal the decision by submitting a request for a brief adjudicative proceeding to the PEBB appeals unit.

(a) The request for a brief adjudicative proceeding from a current or former employee must be received by the PEBB appeals unit no later than ((~~thirty~~)) 30 days after the date of the denial notice. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(b) The request for a brief adjudicative proceeding from a retiree, a continuation coverage enrollee, a retired employee or retired school employee continuing PEBB health plan coverage when their employer group ceases participation, or ((~~self-pay subscriber~~)) a survivor must be received by the PEBB appeals unit no later than ((~~sixty~~)) 60 days after the date of the denial notice. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(3) The PEBB appeals unit must notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(4) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(5) If a subscriber fails to timely request a brief adjudicative proceeding, the decision of the PEBB wellness incentive program contracted vendor becomes the authority's final order without further action.

AMENDATORY SECTION (Amending WSR 22-13-158, filed 6/21/22, effective 1/1/23)

WAC 182-16-2050 How can an employee appeal a decision regarding the administration of benefits offered under the salary reduction plan? (1) Any employee who disagrees with a decision that denies eligibility for, or enrollment in, a benefit offered under the salary reduction plan may appeal that decision by submitting a written request for administrative review to their state agency. The state agency must receive the written request for administrative review no later than 30 days after the date of the denial. The contents of the written request for administrative review are to be provided as described in WAC 182-16-2070.

(a) Upon receiving the written request for administrative review, the state agency must perform a complete review of the denial by one or more staff who did not take part in the decision resulting in the denial.

(b) The state agency must render a written decision within 30 days of receiving the written request for administrative review. The written decision must be sent to the employee who submitted the written request for review and must include a description of appeal rights. The state agency must also send a copy of the state agency's written decision to the state agency's administrator (or designee) and to the PEBB appeals unit. If a state agency fails to render a written decision within 30 days of receiving the written request for administrative review, the request for administrative review may be considered denied as of the 31st day and the original underlying state agency decision may be appealed to the PEBB appeals unit by following the process in this section.

(2) Any employee who disagrees with the state agency's decision in response to a written request for administrative review, as described in this section, may request a brief adjudicative proceeding to be conducted by the authority by submitting a written request to the PEBB appeals unit.

(a) The PEBB appeals unit must receive the request for a brief adjudicative proceeding no later than 30 days after the date of the state agency's written decision on the request for administrative re-

view. If a state agency fails to render a written decision within 30 days of receiving a written request for administrative review, the PEBB appeals unit must receive the request for a brief adjudicative proceeding no later than 30 days after the date the request for administrative review was deemed denied. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(i) The PEBB appeals unit must notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(ii) Once the PEBB appeals unit receives a request for a brief adjudicative proceeding, the PEBB appeals unit will send a request for documentation and information to the applicable state agency. The state agency will then have two business days to respond to the request and provide the documentation and information requested. The state agency will also send a copy of the documentation and information to the employee.

(iii) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(b) If an employee fails to timely request a brief adjudicative proceeding, the state agency's prior written decision becomes the authority's final order without further action.

(3) Any employee aggrieved by a decision regarding a claim for benefits under the ((~~medical~~)) flexible spending arrangement or limited purpose flexible spending arrangement (FSA) or dependent care assistance program (DCAP) offered under the salary reduction plan may appeal that decision to the authority's contracted vendor by following the appeal process of that contracted vendor.

(a) Any employee who disagrees with a decision in response to an appeal filed with the contracted vendor that administers the ((~~medical~~)) FSA, limited purpose FSA, and DCAP under the salary reduction plan may request a brief adjudicative proceeding by submitting a written request to the PEBB appeals unit. The PEBB appeals unit must receive the request for a brief adjudicative proceeding no later than 30 days after the date of the contracted vendor's appeal decision. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(i) The PEBB appeals unit must notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(ii) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(b) If an employee fails to timely request a brief adjudicative proceeding, the contracted vendor's prior written decision becomes the authority's final order without further action.

(4) Any employee aggrieved by a decision regarding the administration of the premium payment plan offered under the salary reduction plan may request a brief adjudicative proceeding to be conducted by the authority by submitting a written request to the PEBB appeals unit for a brief adjudicative proceeding.

(a) The PEBB appeals unit must receive the request for a brief adjudicative proceeding no later than 30 days after the date of the denial notice by the PEBB program. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(i) The PEBB appeals unit must notify the appellant in writing when the notice of appeal has been received.

(ii) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(b) If an employee fails to timely request a brief adjudicative proceeding, the PEBB program's prior written decision becomes the authority's final order without further action.

AMENDATORY SECTION (Amending WSR 20-16-062, filed 7/28/20, effective 1/1/21)

WAC 182-16-2060 How can an entity or organization appeal a decision of the health care authority to deny an employer group application? (1) An entity or organization whose employer group application to participate in public employees benefits board (PEBB) insurance coverage is denied by the authority may appeal the decision by submitting a request for a brief adjudicative proceeding to the ((~~public employees benefits board (~~))PEBB((~~)~~)) appeals unit. For rules regarding eligible entities, see WAC 182-12-111.

(2) The PEBB appeals unit must receive the request for a brief adjudicative proceeding no later than ((~~thirty~~)) 30 days after the date of the denial notice. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(3) The PEBB appeals unit must notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(4) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(5) Failing to timely request a brief adjudicative proceeding will result in the prior PEBB program decision becoming the authority's final order without further action.

WSR 24-18-077
PERMANENT RULES
HEALTH CARE AUTHORITY
(Public Employees Benefits Board)
[Admin #2024-01.02—Filed August 29, 2024, 1:41 p.m., effective January 1, 2025]

Effective Date of Rule: January 1, 2025.

Purpose: The purpose of this proposal is to amend existing rules to support the public employees benefits board (PEBB) program:

1. Implement statutory changes:

In response to SHB 1804, section 1, chapter 312, Laws of 2023, the following definitions are amended:

- Amended the definition of "PEBB Program" to include statutory reference in WAC 182-08-015, 182-12-109, and 182-16-020.
- Amended the definition of "subscriber" to include retired employee or retired school employee continuing health plan coverage when their employer group ceases participation with the authority and clarified PEBB participating employer group in WAC 182-08-015, 182-12-109, and 182-16-020.

In response to SSB 5275, section 2, chapter 13, Laws of 2023, the following definitions are amended:

- Amended the definition of "employer group" to include an employer group obtaining school employees benefits through the school employees benefits board (SEBB) program and clarified the employer group for the PEBB program by adding a statutory reference in WAC 182-08-015, 182-12-109, and 182-16-020.
- Amended the definition of "employer-paid coverage" to include an employer group obtaining school employees benefits through the SEBB program in WAC 182-12-109.
- Created the definitions of "school employee" and "SEBB" in WAC 182-08-015.
- Created the definition of "school employee" in WAC 182-16-020.
- Amended the definition of "school employee" to include represented employees of Educational Service Districts, and include school employees of employee organizations representing school employees and employees of a tribal school in WAC 182-12-109.

In response to SB 5700, section 3, chapter 51, Laws of 2023, the following definitions are amended:

- Amended the definition of "employee" to remove employees of the Washington state convention and trade center in WAC 182-08-015, 182-12-109, and 182-16-020.
- Amended the definitions of "flexible spending arrangement" or "FSA" and "salary reduction plan" in WAC 182-08-015, 182-12-109, and 182-16-020.
- Amended the definitions of "annual open enrollment"; updated "flexible spending arrangement" in WAC 182-12-109.
- Amended the definition of "special open enrollment" in WAC 182-08-015 and 182-12-109.

2. Make technical amendments:

- Amended the definition of "employee" and removed language related to Washington state Educational Service District in WAC 182-08-015, 182-12-109, and 182-16-020.

- Amended the definitions of "health plan" and "waive" to include vision or any combination of medical, dental, or vision coverages in WAC 182-08-015, 182-12-109, and 182-16-020.
- Amended the definition of "employer-based group health plan" to include vision or any combination of medical, dental, or vision coverages in WAC 182-08-015 and 182-12-109.
- Amended the definition of "employer contribution" to clarify PEBB participating employer group in WAC 182-12-109.
- Removed the definition of "employer-paid coverage" in WAC 182-08-015.

Citation of Rules Affected by this Order: Amending WAC 182-08-015, 182-12-109, and 182-16-020.

Statutory Authority for Adoption: RCW 41.05.021, 41.06.065, and 41.05.160; SHB 1804, section 1, chapter 312, Laws of 2023; SSB 5275, section 2, chapter 13, Laws of 2023; and SB 5700, section 3, chapter 51, Laws of 2023

Adopted under notice filed as WSR 24-14-125 on July 2, 2024.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 3, Repealed 0.

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

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 3, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 3, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 3, Repealed 0.

Date Adopted: August 29, 2024.

Wendy Barcus
Rules Coordinator

OTS-5518.2

AMENDATORY SECTION (Amending WSR 22-13-158, filed 6/21/22, effective 1/1/23)

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 (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), the ((~~medical~~)) flexible spending arrangement (FSA), or limited purpose 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 (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.

"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); and (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, and group vision related to a current employment relationship. It does not include medical ((~~or~~)), dental, or vision 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 PEBB participating employer group for its eligible employees as described under WAC 182-12-114 and 182-12-131.

"Employer group" means:

• For the public employees benefits board as defined in RCW 41.05.011 (9)(a), those counties, municipalities, political subdivisions, the Washington health benefit exchange, tribal governments, and 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.

• For the school employees benefits board as defined in RCW 41.05.011 (9)(b), an employee organization representing school employees and a tribal school as defined in RCW 28A.715.010, obtaining school employee benefits through a contractual agreement with the authority to participate in benefit plans developed by the school employees benefits board as described in WAC 182-30-215.

"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.

"Flexible spending arrangement" or "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.

"Forms" or "form" means both paper forms and forms completed electronically.

"Health plan" means a plan offering medical ((~~or~~)), dental, vision, or ((~~both~~)) 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 10 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 or supplemental dependent 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.

"Limited purpose flexible spending arrangement" or "limited purpose FSA" means a benefit plan whereby eligible state employees may reduce their salary before taxes to pay for dental and vision 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.

"Long-term disability insurance" or "LTD insurance" means employer-paid long-term disability insurance and employee-paid long-term disability insurance offered 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 or as described in RCW 41.05.080 (1)(a)(ii).

"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 95 percent of the additional cost an employee would be required to pay to enroll a spouse or state regis-

tered domestic partner in the public employees benefits board (PEBB) Uniform Medical Plan (UMP) Classic; and

• The benefits have an actuarial value of at least 95 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, limited purpose 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; effective January 1, 2024, all employees of educational service districts; and effective January 1, 2024, pursuant to a contractual agreement with the authority, "school employee" may also include: (a) employees of employee organizations representing school employees, at the option of each such employee organization; and (b) employees of a tribal school as defined in RCW 28A.715.010, if the governing body of the tribal school seeks and receives the approval of the authority to provide any of its insurance programs by contracts with the authority, as provided in RCW 41.05.021 (1)(f) and (g).

"SEBB" means the school employees benefits board.

"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 (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, limited purpose 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, retired employee or retired school employee continuing health plan coverage when their employer group ceases participation with the authority, or survivor who has been determined eligible by the PEBB program, PEBB participating 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 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. An employee on approved educational leave 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 and PEBB vision.

OTS-5522.1

AMENDATORY SECTION (Amending WSR 23-14-015, filed 6/23/23, effective 1/1/24)

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 (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), the ((~~medical~~)) flexible spending arrangement (FSA), or limited purpose 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 polit-

ical 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); and (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, and group vision related to a current employment relationship. It does not include medical ((~~or~~)), dental, or vision 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 PEBB participating employer group for its eligible employees as described under WAC 182-12-114 and 182-12-131.

"Employer group" means:

• For the public employees benefits board as defined in RCW 41.05.011 (9)(a), those counties, municipalities, political subdivisions, the Washington health benefit exchange, tribal governments, and 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 author-

ity to participate in benefit plans developed by the public employees benefits board as described in WAC 182-08-245.

• For the school employees benefits board as defined in RCW 41.05.011 (9)(b), an employee organization representing school employees and a tribal school as defined in RCW 28A.715.010, obtaining school employee benefits through a contractual agreement with the authority to participate in benefit plans developed by the school employees benefits board as described in WAC 182-30-215.

"Employer-paid coverage" means PEBB insurance coverage for which an employer contribution is made by a state agency or ((~~an~~)) a PEBB participating 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 a SEBB participating employer group, 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.

"Flexible spending arrangement" or "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.

"Forms" or "form" means both paper forms and forms completed electronically.

"Health plan" means a plan offering medical ((~~or~~)), dental, vision, or ((~~both~~)) any combination of these coverages, 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 or supplemental dependent 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.

"Limited purpose flexible spending arrangement" or "limited purpose FSA" means a benefit plan whereby eligible state employees may reduce their salary before taxes to pay for dental and vision 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.

"Long-term disability insurance" or "LTD insurance" means employer-paid long-term disability insurance and employee-paid long-term disability insurance offered 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 or as described in RCW 41.05.080 (1)(a)(ii).

"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 95 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 95 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, limited purpose 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; ((~~and~~)) represented employees of educational service districts; effective January 1, 2024, all employees of educational service districts; and effective January 1, 2024, pursuant to a contractual agreement with the authority, "school employee" may also include: (a) Employees of employee organizations representing school employees, at the option of each such employee organization; and (b) employees of a tribal school as defined in RCW 28A.715.010, if the governing body of the tribal school seeks and receives the approval of the authority to provide any of its insurance programs by contracts with the authority, as provided in RCW 41.05.021 (1)(f) and (g).

"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 11 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 (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, limited purpose 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, retired employee or retired school employee continuing health plan coverage when their employer group ceases participation

with the authority, or survivor who has been determined eligible by the PEBB program, PEBB participating 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 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. An employee on approved educational leave 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 and PEBB vision.

OTS-5527.1

AMENDATORY SECTION (Amending WSR 22-13-158, filed 6/21/22, effective 1/1/23)

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, reviewing 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); and (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:

• For the public employees benefits board as defined in RCW 41.05.011 (9)(a), those counties, municipalities, political subdivisions, the Washington health benefit exchange, tribal governments, and 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.

• For the school employees benefits board as defined in RCW 41.05.011 (9)(b), an employee organization representing school employees and a tribal school as defined in RCW 28A.715.010, obtaining school employee benefits through a contractual agreement with the authority to participate in benefit plans developed by the school employees benefits board as described in WAC 182-30-215.

"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, reviewing 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.

"Flexible spending arrangement" or "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.

"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, vision, or ((~~both~~)) 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.

"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 or supplemental dependent 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.

"Limited purpose flexible spending arrangement" or "limited purpose FSA" means a benefit plan whereby eligible state employees may reduce their salary before taxes to pay for dental and vision 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.

"Long-term disability insurance" or "LTD insurance" means employer-paid long-term disability insurance and employee-paid long-term disability insurance offered 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 chap-~~

~~ter 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 or as described in RCW 41.05.080 (1)(a)(ii).

"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 95 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 95 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.

"Reviewing 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, limited purpose 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; effective January 1, 2024, all employees of educational service districts; and effective January 1, 2024, pursuant to a contractual agreement with the authority, "school employee" may also include: (a) Employees of employee organi-

zations representing school employees, at the option of each such employee organization; and (b) Employees of a tribal school as defined in RCW 28A.715.010, if the governing body of the tribal school seeks and receives the approval of the authority to provide any of its insurance programs by contracts with the authority, as provided in RCW 41.05.021 (1)(f) and (g).

"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, retired employee or retired school employee continuing health plan coverage when their employer group ceases participation with the authority, or survivor who has been determined eligible by the PEBB program, PEBB participating 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 24-18-078
PERMANENT RULES
HEALTH CARE AUTHORITY
(Public Employees Benefits Board)
[Admin #2024-01.03—Filed August 29, 2024, 1:55 p.m., effective January 1, 2025]

Effective Date of Rule: January 1, 2025.

Purpose: The purpose of this proposal is to amend WAC 182-08-180 to support the public employees benefits board (PEBB) program:

1. Implement statutory changes:

- In response to SHB 1804, section 1, chapter 312, Laws of 2023, HCA implemented to include language that addresses a retired employee, a retired school employee, or a survivor electing to enroll in PEBB health plan coverage when their employer group ceases participation.
- In response to HB 2481, section 1, chapter 185, Laws of 2024, HCA implemented to include language that addresses when premiums and applicable premium surcharges are waived for a retiree who dies.

2. Make technical amendments:

- Included PEBB vision premiums and applicable premium surcharges be made to HCA.
- Included uniform medical plan classic medicare plan to address medicare Part D late enrollment penalty.
- Created exceptions to include subscribers who are electing PEBB retiree insurance coverage but not required to make the first premium payment and applicable premium surcharges to begin enrollment.
- Updated WAC references.

Citation of Rules Affected by this Order: Amending WAC 182-08-180.

Statutory Authority for Adoption: RCW 41.05.021, 41.06.065 [41.05.065], and 41.05.160; SHB 1804, section 1, chapter 312, Laws of 2023; HB 2481, section 1, chapter 185, Laws of 2024.

Adopted under notice filed as WSR 24-14-128 on July 2, 2024.

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

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

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

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

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

Date Adopted: August 29, 2024.

Wendy Barcus
Rules Coordinator

OTS-5520.1

AMENDATORY SECTION (Amending WSR 22-13-158, filed 6/21/22, effective 1/1/23)

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, except as described in (e) of this subsection.

(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) or (7), 182-12-211, and 182-12-265 (1), (2)(d), and (3); 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; or a retired employee, a retired school employee, or a survivor electing to enroll in PEBB health plan coverage when their employer group ceases participation as described in WAC 182-12-232, the first premium payment and applicable premium surcharges are due to the health care authority (HCA) or the contracted vendor no later than 45 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, PEBB vision, or long-term disability (LTD) insurance coverage. Any medicare part D late enrollment penalty associated with the medicare advantage-prescription drug plan or Uniform Medical Plan Classic medicare 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.

Exceptions:
(1) A subscriber electing to enroll in PEBB retiree insurance coverage who elects to pay premiums by deducting from their Washington state department of retirement systems pension retirement benefit is not required to make the first premium payment and applicable premium surcharges to begin enrollment. If there is a delay in the deduction from the pension when the subscriber first enrolls, HCA will send an invoice to the subscriber for the first premium payment and applicable premium surcharges.
(2) A subscriber enrolled in continuation coverage as defined in WAC 182-08-015 or 182-30-020 who is electing to enroll in PEBB retiree insurance coverage, or a subscriber enrolled in continuation coverage as defined in WAC 182-08-015 who is electing to enroll in another type of continuation coverage is not required to make the first premium payment and applicable premium surcharges to begin the new enrollment.

(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.

Exception:
An employee who is on a leave of absence and maintains eligibility for the employer contribution, will have their premiums waived for their employee-paid LTD insurance for the first 90 days. For this purpose, "leave of absence" is defined as a paid or unpaid temporary or indefinite administrative leave, involuntary leave, sick leave, or insurance continued under the federal Family and Medical Leave Act, or paid family and medical leave program as described in WAC 182-12-138.

(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 contracted vendor. For subscribers not eligible for the employer contribution, monthly premiums or applicable premium surcharges that remain unpaid for 30 days will be considered delinquent. A subscriber is allowed a grace period of 30 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 60 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 12 months in duration with the subscriber or the subscriber's legal representative upon request.

Exception: For a subscriber enrolled in a medicare advantage ((~~or~~)) plan, a medicare advantage-prescription drug plan, or the Uniform Medical Plan Classic medicare 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 30 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 30 days past the date the monthly premiums or applicable premium surcharges were due.

(e) When an enrolled retiree dies on or after June 6, 2024, the premium payments for PEBB medical, PEBB dental, PEBB vision, and any applicable premium surcharges for the retiree will be waived by HCA for the month in which the death occurred. Subscribers enrolled as described in WAC 182-12-265 (2)(c) will be responsible for their continued payment of premiums and applicable premium surcharges as described in this section.

(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 60-day adjustment period, except as indicated in WAC 182-12-148(5).

(b) When premiums and applicable premium surcharges are waived for a retiree who dies as described in subsection (1)(e) of this section, HCA will refund any excess premiums and applicable premium surcharges paid to the retiree's estate, to the department of retirement systems, or apply any excess premiums to the surviving dependent's account.

(c) 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 60 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 12 months of premiums; and

(ii) Approve the enrollment change that was originally requested and which forms the basis for the refund.

((~~(c)~~)) (d) 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)~~)) (e) HCA errors will be corrected by returning all excess premiums and applicable premium surcharges paid by the employing agency, subscriber, or beneficiary.

((~~(e)~~)) (f) 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).

WSR 24-18-080
PERMANENT RULES
HEALTH CARE AUTHORITY
(Public Employees Benefits Board)
[Admin #2024-01.04—Filed August 29, 2024, 2:51 p.m., effective January 1, 2025]

Effective Date of Rule: January 1, 2025.

Purpose: The purpose of this proposal is to amend rules to support the public employees benefits board (PEBB) program:

1. Amended WAC 182-12-171 and 182-12-211 to implement statutory changes:

- In response to HB 1008, section 1, chapter 164, Laws of 2023, HCA amended WAC 182-12-171 and 182-12-211 to include separated employees and clarified the requirement for a retiring employee who is a member of Plan 3 retirement system.
- In response to SHB 1804, section 1, chapter 312, Laws of 2023, HCA amended WAC 182-12-171 to update WAC references.
- In response to SB [SSB] 5275, section 5, chapter 13, Laws of 2023, HCA amended WAC 182-12-171 and 182-12-211 to add eligibility requirements for retiring school employees of a SEBB participating employer group.

2. Amended WAC 182-12-171 and 182-12-211 to implement the following PEBB policy resolutions:

- PEBB 2024-14 Non-medicare retiree enrollment requirement.
- PEBB 2024-19 UMP classic medicare enrollment.
- PEBB 2024-20 UMP classic medicare plan enrollment during gap month(s).
- PEBB 2024-21 Amending 2022-03 medicare advantage prescription drug plan.

3. Make other technical amendments:

- Amended WAC 182-12-171 to include an exception when the first premium payment and applicable premium surcharges are due to HCA and clarified PEBB participating employer group and UMP classic medicare plan enrollment procedures.

4. Implement emergency rules:

- This permanent filing includes the information in the emergency rules filed under WSR 24-11-151 primarily for WAC 182-12-5110. It also includes the information in the emergency rules filed under WSR 24-18-023 for WAC 182-12-5200. Once the permanent rules take effect, the emergency rules will no longer be needed and the temporary WAC 182-12-5110 and 182-12-5200 will not be retained.

Citation of Rules Affected by this Order: Amending WAC 182-12-171 and 182-12-211.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.065, and 41.05.160; HB 1008, section 1, chapter 164, Laws of 2023; SHB 1804, Section 1, chapter 312, Laws of 2023; SSB 5275, section 5, chapter 13, Laws of 2023.

Other Authority: Policy Resolutions PEBB 2024-14, 2024-19, 2024-20, and 2024-21.

Adopted under notice filed as WSR 24-14-130 on July 2, 2024.

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

Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 2, Repealed 0.

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

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

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

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

Date Adopted: August 29, 2024.

Wendy Barcus
Rules Coordinator

OTS-5525.1

AMENDATORY SECTION (Amending WSR 23-14-015, filed 6/23/23, effective 1/1/24)

WAC 182-12-171 When is a retiring employee or a retiring school employee eligible to enroll in public employees benefits board (PEBB) retiree insurance coverage? A retiring employee or a retiring school employee is eligible to continue enrollment or defer enrollment in public employees benefits board (PEBB) insurance coverage as a retiree if they meet procedural and substantive eligibility requirements as described in subsections (1), (2), and (3) of this section. An elected and full-time appointed official of the legislative and executive branch of state government is eligible as described in WAC 182-12-180.

(1) **Procedural requirements.** A retiring employee or a retiring school employee must enroll or defer enrollment in PEBB retiree insurance coverage as described in (a) through ((~~(d)~~)) (e) of this subsection:

(a) To enroll in PEBB retiree insurance coverage, the required form must be received by the PEBB program no later than 60 days after the employee's or the school employee's own employer-paid coverage, Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage, or continuation coverage ends. The effective date of PEBB retiree insurance coverage is the first day of the month after the employee's or the school employee's employer-paid coverage, COBRA coverage, or continuation coverage ends;

Note: Enrollment in the PEBB program's medicare advantage (MA) ((~~or~~)) plan, medicare advantage-prescription drug (MA-PD) plan, or the Uniform Medical Plan (UMP) Classic medicare plan may not be retroactive.
(1) If a subscriber elects to enroll in a MA plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in a plan with the same contracted vendor during the gap month(s) prior to when MA coverage begins.
(2) If a subscriber elects to enroll in a MA-PD plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in ((~~Uniform Medical Plan (UMP) Classic~~)) transitional coverage as designated by the director or designee during the gap month(s) prior to when the MA-PD coverage begins.
(3) If a subscriber elects to enroll in the UMP Classic medicare plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in transitional UMP coverage during the gap month(s) prior to when the UMP Classic medicare plan begins.

(b) The employee's or the school employee's first premium payment for PEBB retiree insurance coverage and applicable premium surcharges are due to the health care authority (HCA) no later than 45 days after

the election period ends as described in (a) of this subsection, except as described in WAC 182-08-180 (1)(a). Following the employee's or the school employee's first premium payment, premiums and applicable premium surcharges must be paid as described in WAC 182-08-180 (1)(c); and

(c) If a retiring employee or a retiring school employee elects to enroll a dependent in PEBB health plan coverage, the dependent must be enrolled in the same PEBB medical and PEBB dental plan as the retiring employee or the retiring school employee;

Exceptions: (1) If a retiring employee or a retiring school employee selects a medicare supplement plan ((~~or~~)), a MA-PD plan, or the UMP Classic medicare plan, nonmedicare enrollees will be enrolled in the UMP Classic. If a retiring employee or a retiring school employee selects any other medicare plan, they must also select a nonmedicare plan with the same contracted vendor available to nonmedicare enrollees. (2) If a retiring employee or a retiring school employee selects a medicare supplement plan, MA-PD plan, or any other medicare plan, they may elect a PEBB vision plan available for any nonmedicare enrollees.

(d) A nonmedicare retiring employee or retiring school employee must enroll in PEBB medical to be able to enroll in PEBB dental, in PEBB vision, or in both PEBB dental and PEBB vision. Any nonmedicare dependents they elect to enroll must be enrolled in the same PEBB medical, PEBB dental, and PEBB vision plan.

(e) To defer enrollment in PEBB retiree insurance coverage, the employee or the school employee must meet substantive eligibility requirements in subsection (2) of this section and defer enrollment as described in WAC 182-12-200 or 182-12-205.

(2) **Substantive eligibility requirements.**

An employee who is eligible for PEBB benefits through an employing agency, or a school employee who is eligible for SEBB benefits through a SEBB organization, a SEBB participating employer group, or basic benefits through an educational service district as defined in RCW 28A.400.270 who ends public employment may enroll or defer enrollment in PEBB retiree insurance coverage if they meet procedural and substantive eligibility requirements.

To be eligible to continue enrollment or defer enrollment in PEBB retiree insurance coverage, the employee or the school employee must be vested in and eligible to retire under a Washington state-sponsored retirement plan when the employee's or school employee's own employer-paid coverage, COBRA coverage, or continuation coverage ends. An exception to the requirement to be vested in and eligible to retire under a Washington state-sponsored retirement plan is provided for employees of ((~~an~~)) a PEBB participating employer group in (c)(i) of this subsection and for school employees of a SEBB participating employer group in (e)(i) of this subsection. To satisfy the requirement to immediately begin to receive a monthly retirement plan payment as described in (a), (b), (c)(ii), ((~~and~~)) (d), and (e)(ii) of this subsection, the employee or school employee must begin receiving a monthly retirement plan payment no later than the first month following the employee's or school employee's own employer-paid coverage, COBRA coverage, or continuation coverage ending.

(a) A retiring employee of a state agency must immediately begin to receive a monthly retirement plan payment, with exceptions described below:

(i) A retiring employee who receives a lump sum payment instead of a monthly retirement plan payment is only eligible if the department of retirement systems offered the employee the choice between a lump sum actuarially equivalent payment and the ongoing monthly payment, as allowed by the plan; or

(ii) A retiring employee who is a member of the teachers' retirement system Plan 2, school employees' retirement system Plan 2, or public employees' retirement system Plan 2, also called a separated

employee as defined in RCW 41.05.011 (25)(b), who separates from employment on or after January 1, 2024, and who is at least age 55 with at least 20 years of service; or

(iii) A retiring employee who is a member of a Plan 3 retirement plan, also called a separated employee ((~~(~~))as defined in RCW 41.05.011 (25)(a)((~~), must meet their Plan 3 retirement eligibility criteria. The employee does not have to receive a retirement plan payment to enroll in PEBB retiree insurance coverage~~)), who is at least age 55 with at least 10 years of service.

(b) A retiring employee of a Washington higher education institution who is a member of a higher education retirement plan (HERP) must immediately begin to receive a monthly retirement plan payment, or meet their HERP plan's retirement eligibility criteria, or be at least age 55 with 10 years of state service;

(c) A retiring employee of an employer group participating in PEBB insurance coverage under contractual agreement with the authority must be eligible to retire as described in (c)(i) or (ii) of this subsection to be eligible to continue PEBB retiree insurance coverage.

(i) A retiring employee who is eligible to retire under a retirement plan sponsored by an employer group or tribal government that is not a Washington state-sponsored retirement plan must meet the same age and years of service requirements as if they were a member of public employees retirement system Plan 1, if their date of hire with that employer group or tribal government was before October 1, 1977, or Plan 2, if their date of hire with that employer group or tribal government was on or after October 1, 1977.

(ii) A retiring employee who is eligible to retire under a Washington state-sponsored retirement plan must immediately begin to receive a monthly retirement plan payment, with exceptions described in (a)(i) ((~~and~~)), (ii), or (iii) of this subsection.

(iii) A retired employee of an employer group that ends participation in PEBB insurance coverage is no longer eligible to continue enrollment in PEBB retiree insurance coverage if they enrolled after September 15, 1991. Any retiree who loses eligibility for this reason may continue health plan enrollment as described in WAC ((~~182-12-146~~)) 182-12-232.

(iv) A retired employee of a tribal government employer that ends participation in PEBB insurance coverage is no longer eligible to continue enrollment in PEBB retiree insurance coverage. Any retiree who loses eligibility for this reason may continue health plan enrollment as described in WAC ((~~182-12-146~~)) 182-12-232.

(d) A retiring school employee of a SEBB organization must immediately begin to receive a monthly retirement plan payment, with exceptions described below:

(i) A retiring school employee who ends employment before October 1, 1993; or

(ii) A retiring school employee who receives a lump sum payment instead of a monthly retirement plan payment is only eligible if the department of retirement systems offered the school employee the choice between a lump sum actuarially equivalent payment and the ongoing monthly payment, as allowed by the plan, or the school employee enrolled before 1995; or

(iii) A retiring school employee who is a member of the teachers' retirement system Plan 2, school employees' retirement system Plan 2, or public employees' retirement system Plan 2, also called a separated employee as defined in RCW 41.05.011 (25)(b), who separates from em-

ployment on or after January 1, 2024, and who is at least age 55 with at least 20 years of service; or

(iv) A retiring school employee who is a member of a Plan 3 retirement system, also called a separated employee ((~~(~~))as defined in RCW 41.05.011 (25)(a)((~~(~~), ~~must meet their Plan 3 retirement eligibility criteria~~)), who is at least age 55 with at least 10 years of service; or

((~~(iv)~~)) (v) A school employee who retired as of September 30, 1993, and began receiving a monthly retirement plan payment from a Washington state-sponsored retirement system (as defined in chapters 41.32, 41.35 or 41.40 RCW) is eligible if they enrolled in a PEBB health plan no later than the HCA's annual open enrollment period for the year beginning January 1, 1995.

(e) A retiring school employee of an employer group participating in SEBB insurance coverage under contractual agreement with the authority must be eligible to retire as described in (e)(i) or (ii) of this subsection to be eligible to continue PEBB retiree insurance coverage.

(i) A retiring school employee who is eligible to retire under a retirement plan sponsored by an employer group that is not a Washington state-sponsored retirement plan must meet the same age and years of service requirements as if they were a member of teachers retirement system Plan 1, if their date of hire with that employer group was before October 1, 1977, or Plan 2, if their date of hire with that employer group was on or after October 1, 1977.

(ii) A retiring school employee who is eligible to retire under a Washington state-sponsored retirement plan must immediately begin to receive a monthly retirement plan payment, with exceptions described in (d)(ii), (iii), or (iv) of this subsection.

(iii) A retired school employee of an employer group that ends participation in SEBB insurance coverage is no longer eligible to continue enrollment in PEBB retiree insurance coverage. Any retiree who loses eligibility for this reason may continue health plan enrollment as described in WAC 182-12-232.

(3) A retiring employee or a retiring school employee and their enrolled dependents who are eligible for medicare must enroll and maintain enrollment in both medicare Parts A and B if the employee or the school employee retired after July 1, 1991. If a retiree or an enrolled dependent becomes eligible for medicare after enrollment in PEBB retiree insurance coverage, they must enroll and maintain enrollment in medicare Parts A and B to remain enrolled in a PEBB retiree health plan. If an enrollee who is eligible for medicare does not meet this procedural requirement, the enrollee is no longer eligible for enrollment in a PEBB retiree health plan. The enrollee's eligibility will end as described in the termination notice sent by the PEBB program. The enrollee may continue PEBB health plan enrollment as described in WAC 182-12-146.

Note: For the exclusive purpose of medicare Part A as described in this subsection, "eligible" means the enrollee is eligible for medicare Part A without a monthly premium.

(4) Washington state-sponsored retirement plans include:

(a) Higher education retirement plans;

(b) Law enforcement officers' and firefighters' retirement system;

(c) Public employees' retirement system;

(d) Public safety employees' retirement system;

(e) School employees' retirement system;

(f) State judges/judicial retirement system;

(g) Teachers' retirement system; and
(h) State patrol retirement system.
(i) The two federal retirement systems, Civil Service Retirement System and Federal Employees' Retirement System, are considered Washington state-sponsored retirement systems for Washington State University Extension for an employee covered under PEBB benefits at the time of retirement.

AMENDATORY SECTION (Amending WSR 22-13-160, filed 6/21/22, effective 1/1/23)

WAC 182-12-211 May an employee or a school employee who is determined to be retroactively eligible for disability retirement enroll or defer enrollment in public employees benefits board (PEBB) retiree insurance coverage? (1) An employee or a school employee who is determined to be retroactively eligible for a disability retirement is eligible to enroll or defer enrollment (as described in WAC 182-12-200 or 182-12-205) in public employees benefits board (PEBB) retiree insurance coverage if:
(a) The employee or the school employee submits the required form and a copy of the formal determination letter they received from the Washington state department of retirement systems (DRS) or the appropriate higher education authority;
(b) The employee's or the school employee's form and a copy of their Washington state-sponsored retirement system's formal determination letter are received by the PEBB program no later than 60 days after the date on the determination letter; and
(c) The employee or the school employee immediately begins to receive a monthly pension benefit or a supplemental retirement plan benefit under their higher education retirement plan (HERP), with exceptions described below from WAC 182-12-171(2):
(i) A retiring employee of a state agency, ((~~an~~)) a retiring school employee of a school employees benefits board (SEBB) organization, or a retiring employee or a retiring school employee of an employer group participating under a Washington state sponsored retirement plan((~~, or a retiring school employee~~)) who receives a lump sum payment instead of a monthly retirement plan payment is only eligible if the department of retirement systems offered the employee the choice between a lump sum actuarially equivalent payment and the ongoing monthly payment, as allowed by the plan; or
(ii) A retiring employee of a state agency, a retiring school employee of a SEBB organization, or a retiring employee or retiring school employee of an employer group participating under a Washington state sponsored retirement plan who is a member of the teachers' retirement system Plan 2, school employees' retirement system Plan 2, or public employees' retirement system Plan 2, also called a separated employee as defined in RCW 41.05.011 (25)(b), who separates from employment on or after January 1, 2024, and who is at least age 55 with at least 20 years of service; or
(iii) A retiring employee of a state agency, ((~~an~~)) a retiring school employee of a SEBB organization, or a retiring employee or a retiring school employee of an employer group participating under a Washington state sponsored retirement plan((~~, or a retiring school employee~~)) who is a member of a Plan 3 retirement plan, also called a separated employee ((~~(~~))as defined in RCW 41.05.011 (25)(a)((~~), must~~

~~meet their Plan 3 retirement eligibility criteria. The employee or the school employee does not have to receive a retirement plan payment to enroll in PEBB retiree insurance coverage~~)), who is at least age 55 with at least 10 years of service; or

((~~(iii)~~)) (iv) A retiring employee of a Washington higher education institution who is a member of a higher education retirement plan (HERP) must immediately begin to receive a monthly retirement plan payment, or meet their HERP plan's retirement eligibility criteria, or be at least age 55 with 10 years of state service.

(2) The employee or the school employee, at their option, must indicate the date of enrollment or deferment in PEBB retiree insurance coverage on the form. The employee or the school employee may choose from the following dates:

(a) The retirement date as stated in the formal determination letter; or

(b) The first day of the month following the date the formal determination letter was written.

Note: Enrollment in the PEBB program's medicare advantage (MA) ((~~or~~)) plan, medicare advantage-prescription drug (MA-PD) plan, or the Uniform Medical Plan (UMP) Classic medicare plan may not be retroactive.
(1) If a subscriber elects to enroll in a MA plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in a plan with the same contracted vendor during the gap month(s) prior to when the MA coverage begins.
(2) If a subscriber elects to enroll in a MA-PD plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in ((~~Uniform Medical Plan (UMP) Classic~~)) transitional coverage as designated by the director or designee during the gap month(s) prior to when the MA-PD coverage begins.
(3) If a subscriber elects to enroll in the UMP Classic medicare plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in transitional UMP coverage during the gap month(s) prior to when the UMP Classic medicare plan begins.

(3) The director may make an exception to the date of PEBB retiree insurance coverage described in subsection (2)(a) and (b) of this section; however, such request must demonstrate extraordinary circumstances beyond the control of the retiree.

(4) Premiums and applicable premium surcharges are due from the effective date of enrollment in PEBB retiree insurance coverage.

(5) If a retiring employee or a retiring school employee elects to enroll a dependent in PEBB health plan coverage, the dependent must be enrolled in the same PEBB medical and PEBB dental plan as the retiring employee or the retiring school employee.

Exceptions: (1) If a retiring employee or a retiring school employee selects a medicare supplement plan ((~~or~~)), MA-PD plan, or the UMP Classic medicare plan, nonmedicare enrollees will be enrolled in the UMP Classic. If a retiring employee or a retiring school employee selects any other medicare plan, they must also select a nonmedicare plan with the same contracted vendor available to nonmedicare enrollees.
(2) If a retiring employee or a retiring school employee selects a medicare supplement plan, MA-PD plan, or any other medicare plan, they may elect a PEBB vision plan available for any nonmedicare enrollees.

(6) A nonmedicare retiring employee or retiring school employee must enroll in PEBB medical to be able to enroll in PEBB dental, in PEBB vision, or in both PEBB dental and PEBB vision. Any nonmedicare dependents they elect to enroll must be enrolled in the same PEBB medical, PEBB dental, and PEBB vision plan.

WSR 24-18-081
PERMANENT RULES
HEALTH CARE AUTHORITY
(Public Employees Benefits Board)
[Admin #2024-01.05—Filed August 29, 2024, 3:06 p.m., effective January 1, 2025]

Effective Date of Rule: January 1, 2025.

Purpose: The purpose of this proposal is to amend rules to support the public employees benefits board (PEBB) program:

1. Implement statutory changes in response to SHB 1804, section 1, chapter 312, Laws of 2023:

- Amended WAC 182-08-245 to include a new subsection.
- Amended WAC 182-12-146 by updating a subsection and adding a new subsection.
- Created WAC 182-12-232.
- Amended WAC 182-12-262 to add a reference to WAC 182-12-232.

2. Implement the following PEBB policy resolutions:

- PEBB 2024-14 Non-medicare retiree enrollment requirement.
- PEBB 2024-19 UMP classic medicare enrollment.
- PEBB 2024-20 UMP classic medicare plan enrollment during gap month(s).
- PEBB 2024-21 Amending 2022-03 medicare advantage prescription drug plan.

3. Make other technical amendments:

- Amended WAC 182-08-198 to include uniform medical plan (UMP) classic medicare plan disenrollment procedures.
- Amended WAC 182-08-245 to remove board members of school districts or educational service districts, clarified employer group for the PEBB program, and updated a WAC reference.
- Amended WAC 182-12-146 to include PEBB vision, removed a subsection that applies to [a] board member who longer qualifies as described in WAC 182-12-111 (4)(c), added an exception to the first premium payment and applicable premium surcharges requirement, and added an exception to when a subscriber or their dependent will be disenrolled from a medicare advantage plan, a medicare advantage-prescription drug plan, or the UMP classic medicare plan
- Amended WAC 182-12-262 to update the language that describe[s] a dependent must be enrolled in the same health plan coverage as the subscriber, added PEBB vision and the disenrollment process for UMP classic medicare plan, and updated the description of any other subscriber must submit the required forms to the PEBB program.

4. Implement emergency rules:

- This permanent filing includes the information in the emergency rules filed under WSR 24-11-151 primarily for WAC 182-12-5120. Once the permanent rules take effect, the emergency rule will no longer be needed and the temporary WAC 182-12-5120 will not be retained.

Citation of Rules Affected by this Order: New WAC 182-12-232; and amending WAC 182-08-198, 182-08-245, 182-12-146, and 182-12-262.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.065, and 41.05.160; HB 1008, section 1, chapter 164, Laws of 2023; SHB 1804,

section 1, chapter 312, Laws of 2023; SSB 5275, section 5, chapter 13, Laws of 2023.

Other Authority: Policy Resolutions PEBB 2024-14, 2024-19, 2024-20, and 2024-21.

Adopted under notice filed as WSR 24-14-131 on July 2, 2024.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 1, Amended 3, Repealed 0.

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

Number of Sections Adopted on the Agency's own Initiative: New 1, Amended 3, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 1, Amended 3, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 1, Amended 3, Repealed 0.

Date Adopted: August 29, 2024.

Wendy Barcus
Rules Coordinator

OTS-5521.1

AMENDATORY SECTION (Amending WSR 23-14-016, filed 6/23/23, effective 1/1/24)

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.

A subscriber may not change their health plan during a special open enrollment if their state registered domestic partner or state registered domestic partner's child is not a tax dependent. A sub-

scriber may change their health plan as described in subsection (1) of this section.

To disenroll from a medicare advantage (MA) plan ((~~or~~)), medicare advantage-prescription drug (MA-PD) plan, or the Uniform Medical Plan (UMP) Classic medicare plan, the change in enrollment must be allowable under 42 C.F.R. Secs. 422.62(b) and 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 60 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 except for a MA ((~~or~~)) plan, a MA-PD plan, or the UMP Classic medicare plan which will begin the first day of the month following the date the form is received.

Exception: When a subscriber or their dependent is enrolled in a MA ((~~or~~)) plan, a MA-PD plan, or the UMP Classic medicare plan, they may disenroll during a special enrollment period as allowed under 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.

(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 or their dependent's 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.

(i) If the subscriber has a change in residence and the subscriber's current medical plan is no longer available, the subscriber must select a new medical plan as described in WAC 182-08-196(3);

(ii) If the subscriber or the subscriber's dependent has a change in residence and the subscriber's current dental plan does not have available providers within 50 miles of the subscriber or the subscriber's dependent's new residence, the subscriber may select a new dental plan;

(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~~)) MA-PD 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, a retired employee, a retired school employee, or a survivor enrolled in PEBB health plan coverage after their employer group ceased participation, 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, a retired employee, a retired school employee, or a survivor enrolled in PEBB health plan coverage after their employer group ceased participation, or an eligible subscriber enrolled in ((~~Consolidated Omnibus Budget Reconciliation Act (COBRA)~~)) COBRA coverage has seven months to enroll in a ((~~medicare advantage or medicare advantage-prescription drug~~)) MA plan, MA-PD plan, or the UMP Classic medicare 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~~)) MA plan, MA-PD plan, or the UMP Classic medicare 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~~)) MA plan, MA-PD plan, or the UMP Classic medicare 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;

(l) The PEBB program determines that there has been a substantial decrease in the providers available under a PEBB medical plan.

(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 23-14-015, filed 6/23/23, effective 1/1/24)

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 for the public employees benefits board (PEBB) program 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)~~)) 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. The premium rate structure for employer groups ((~~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~~)) 90 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~~)) wants 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 60 days before the requested termination date. If an employer group terminates participation in PEBB insurance coverage, they must:

(a) Notify all their employees, dependents, or retirees who are enrolled in PEBB insurance coverage 45 days prior to the employer group's date of termination; and

(b) Provide assistance to retirees as described in RCW 41.04.208(12).

(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 ends participation, retired and disabled employees who began participation before September 15, 1991, are eligible to continue enrollment in PEBB retiree insurance coverage if they continue 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 ((~~on the same terms and conditions as retirees who are eligible under COBRA (see WAC 182-12-146)~~)) as described in WAC 182-12-232.

(8) Employer groups that enter into a contractual agreement with the authority on or after May 4, 2023, and whose contractual agreement is subsequently terminated, shall make a one-time payment to the authority for each of the employer group's retired or disabled employees

who continue their participation in insurance plans and contracts under WAC 182-12-232.

(a) For each of the employer group's retired or disabled employees who will be continuing their participation, the authority shall determine the one-time payment by:

(i) Calculating the difference in cost between the rate charged to retired or disabled employees as described in RCW 41.05.080(2); and

(ii) The actuarially determined value of the medical benefits for retired and disabled employees who are not eligible for parts A and B of medicare; and

(iii) Multiplying that difference by the number of months until the retired or disabled employee would become eligible for medicare.

(b) Employer groups shall not be entitled to any refund of the amount paid to the authority as described in this subsection.

OTS-5524.1

AMENDATORY SECTION (Amending WSR 23-14-015, filed 6/23/23, effective 1/1/24)

WAC 182-12-146 When is an enrollee eligible to continue public employees benefits board (PEBB) benefits under Consolidated Omnibus Budget Reconciliation Act (COBRA)? (1) An employee or an employee's dependent who loses eligibility for the employer contribution toward public employees benefits board (PEBB) benefits and who qualifies for continuation coverage under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) may continue coverage for all or any combination of PEBB medical, dental, or ((~~both~~)) vision.

(2) An employee or an employee's dependent who loses eligibility for continuation coverage described in WAC 182-12-133, 182-12-141, 182-12-142, or 182-12-148 but who has not used the maximum number of months allowed under COBRA may continue any combination of PEBB medical, dental, or ((~~both~~)) vision for the remaining difference in months.

(3) A retired employee, a retired school employee, or survivor who loses eligibility for PEBB retiree insurance coverage because ((~~an~~)) their employer group ceases participation ((~~in PEBB insurance coverage~~)) with the authority may continue PEBB medical, dental, or ((~~both on the same terms and conditions as retirees who are eligible under COBRA~~)) vision as described in WAC 182-12-232.

(4) A dependent of a subscriber enrolled as described in WAC 182-12-232 who is no longer eligible as described in WAC 182-12-260 may continue any combination of PEBB medical, dental, or vision.

(5) A retiree or a dependent of a retiree, who is no longer eligible as described in WAC 182-12-171, 182-12-180, or 182-12-260 may continue any combination of PEBB medical, dental, or ((~~both~~)) vision.

((~~(5)~~)) (6) A blind vendor who ceases to actively operate a facility as described in WAC 182-12-111 (4)(a) may continue enrollment in PEBB medical for the maximum number of months allowed under COBRA as described in this section.

((~~(6) A board member who no longer qualifies as described in WAC 182-12-111 (4)(c) may continue enrollment in PEBB medical, dental, or~~

~~both for the maximum number of months allowed under COBRA as described in this section.~~))

(7) An enrollee may continue any combination of PEBB medical, dental, or ((~~both~~)) 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 PEBB program no later than 60 days from the date the enrollee's PEBB health plan coverage ended or from the postmark date on the election notice sent by the PEBB program, whichever is later;

(b) The first premium payment under COBRA coverage and applicable premium surcharges are due to the HCA no later than 45 days after the election period ends as described in (a) of this subsection, except as described in WAC 182-08-180 (1)(a). Following the enrollee's first premium payment, premiums and applicable premium surcharges must be paid as described in WAC 182-08-180 (1)(c);

(c) COBRA continuation coverage enrollees who voluntarily terminate their COBRA coverage will not be eligible to reenroll in COBRA coverage unless they regain eligibility as described in WAC 182-12-114. Those who request to terminate their COBRA coverage must do so in writing. COBRA coverage will end on the last day of the month in which the PEBB program receives the termination request or on the last day of the month specified in the COBRA enrollee's termination request, whichever is later. If the termination request is received on the first day of the month, COBRA coverage will end on the last day of the previous month;

Exception: When a subscriber or their dependent is enrolled in a medicare advantage plan, a medicare advantage-prescription drug plan, or the Uniform Medical Plan Classic medicare plan, the enrollment will terminate on the last day of the month when the plan disenrollment form is received.

(d) An employee enrolled in a ((~~medical~~)) flexible spending arrangement (FSA) or limited purpose FSA and the employee's dependents will have an opportunity to continue making contributions to their ((~~medical~~)) FSA or limited purpose FSA by electing COBRA if on the date of the qualifying event, as described under 42 U.S.C. Sec. 300bb-3, the employee's ((~~medical~~)) FSA or limited purpose 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 60 days from the date the PEBB health plan coverage ended or from the postmark date on the election notice sent by the contracted vendor, whichever is later. The first premium payment under COBRA coverage is due to the contracted vendor no later than 45 days after the election period ends as described above.

(8) A subscriber's state registered domestic partner and the state registered domestic partner's children may continue any combination of PEBB medical, dental, or ((~~both~~)) vision on the same terms and conditions as spouses and other eligible dependents under COBRA as described under RCW 26.60.015.

(9) Medical ((~~and~~)), dental, and vision coverage under COBRA begin on the first day of the month following the day the COBRA enrollee loses eligibility for PEBB health plan coverage as described in WAC 182-12-131, 182-12-133, 182-12-141, 182-12-142, 182-12-148, 182-12-171, 182-12-180, 182-12-250, 182-12-260, or 182-12-265.

NEW SECTION

WAC 182-12-232 What options for continuing health plan enrollment are available to a retiree of an employer group that ended participation in public employees benefits board (PEBB) or school employees benefits board (SEBB) insurance coverage? (1) A retired employee, a retired school employee, or an eligible survivor of an employee, school employee, or retiree of an employer group as defined in WAC 182-12-109 who loses eligibility for public employees benefits board (PEBB) retiree insurance coverage due to the employer group ending participation in PEBB or school employees benefits board (SEBB) insurance coverage may continue enrollment in PEBB health plan coverage by self-paying the premium and applicable premium surcharges set by the health care authority (HCA). A retired employee, a retired school employee, or a survivor enrolled under this section is not eligible for any subsidy provided under RCW 41.05.085.

(2) A retired employee, a retired school employee, or a survivor as described in subsection (1) of this section may enroll in PEBB medical, dental, or vision.

(a) The required forms must be received by the PEBB program no later than 60 days after the employer group's date of termination. The effective date of enrollment in PEBB health plan coverage will be the first day of the month following the day eligibility for PEBB retiree insurance coverage ended.

Note: Enrollment in the PEBB program's medicare advantage (MA) plan, medicare advantage prescription-drug (MA-PD) plan, or the Uniform Medical Plan (UMP) Classic medicare plan may not be retroactive.
(1) If a subscriber elects to enroll in a MA plan, and the required forms are received by the PEBB program after the date the PEBB health plan coverage is to begin, the subscriber and their enrolled dependents will be enrolled in a plan with the same contracted vendor during the gap month(s) prior to when the MA coverage begins.
(2) If a subscriber elects to enroll in a MA-PD plan, and the required forms are received by the PEBB program after the date the PEBB health plan coverage is to begin, the subscriber and their enrolled dependents will be enrolled in transitional coverage as designated by the director or designee during the gap month(s) prior to when the MA-PD coverage begins.
(3) If a subscriber elects to enroll in the UMP Classic medicare plan, and the required forms are received by the PEBB program after the date the PEBB health plan coverage is to begin, the subscriber and their enrolled dependents will be enrolled in transitional UMP coverage during the gap month(s) prior to when the UMP Classic medicare plan begins.

(b) The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends as described in (a) of this subsection. Following the first premium payment, premiums and applicable premium surcharges must be paid as described in WAC 182-08-180 (1)(c).

Note: An employer group as defined in WAC 182-12-109 that enters into a contractual agreement with the HCA on or after May 4, 2023, and whose contractual agreement is subsequently terminated, shall make a one-time payment to the HCA for each of the employer group's retired or disabled employees who continue participation under this section as described in RCW 41.05.083.

(c) If a retired employee, a retired school employee, or a survivor elects to enroll a dependent in PEBB health plan coverage, the dependent must be enrolled in the same PEBB medical and PEBB dental plan as the retired employee, retired school employee, or survivor.

Exceptions: (1) If a retired employee, a retired school employee, or a survivor selects a medicare supplement plan, a MA-PD plan, or the UMP Classic medicare plan, nonmedicare enrollees will be enrolled in the UMP classic. If a retired employee, a retired school employee, or a survivor selects any other medicare plan, they must also select a nonmedicare plan with the same contracted vendor available to nonmedicare enrollees.
(2) If a retired employee, a retired school employee, or a survivor selects a medicare supplement plan, MA-PD plan, or any other medicare plan, they may elect a PEBB vision plan available for any nonmedicare enrollees.

(3) A subscriber enrolled under this section may continue PEBB health plan coverage until they request to terminate enrollment as described in subsection (4) of this section, or premiums and applicable premium surcharges are no longer paid as described in WAC 182-08-180 (1)(c). If PEBB health plan coverage is terminated for these reasons, the subscriber and their enrolled dependents will not be eligible to reenroll under this section.

(4) A subscriber enrolled under this section who requests to voluntarily terminate their PEBB health plan coverage must do so in writing. PEBB health plan coverage will end on the last day of the month in which the PEBB program receives the termination request or on the last day of the month specified in the subscriber's termination request, whichever is later. If the termination request is received on the first day of the month, PEBB health plan coverage will end on the last day of the previous month.

Exception: When a subscriber or their dependent is enrolled in a MA plan, a MA-PD plan, or the UMP Classic medicare plan, the enrollment in PEBB health plan coverage will terminate on the last day of the month when the plan disenrollment form is received.

AMENDATORY SECTION (Amending WSR 23-14-015, filed 6/23/23, effective 1/1/24)

WAC 182-12-262 When may subscribers enroll or remove eligible dependents? (1) **Enrolling dependents in public employees benefits board (PEBB) health plan coverage, 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 ((~~except as described in WAC 182-12-171 (1)(c)~~)) unless otherwise described in the Washington Administrative Code applicable to the subscriber. The subscriber must be enrolled in health plan coverage to enroll their dependent in health plan coverage except as provided in WAC 182-12-205 (3)(c). A dependent with more than one source of eligibility for enrollment in the PEBB and school employees benefits board (SEBB) programs is limited to a single enrollment in medical, dental, and vision plans in either the PEBB or SEBB program. 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 insurance 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 14 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 in health plan coverage 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. Supplemental dependent life insurance or AD&D insurance 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 14 days old before supplemental dependent life insurance or AD&D insurance coverage is effective.

(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). For supplemental dependent life insurance or AD&D insurance, subscribers must notify the contracted vendor on the required form, in writing, or by telephone when a dependent is no longer eligible. Contact information for the contracted vendor may be found at hca.wa.gov/employees-contact-plan. For PEBB health plan coverage, the notice must be received within 60 days of the last day of the month the dependent loses eligibility. Employees must notify their employing agency when a dependent is no longer eligible for PEBB health plan coverage, 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 60 days include, but are not limited to:

(i) The dependent may lose eligibility to continue PEBB medical ((~~or~~)), dental, or vision 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 insurance or AD&D insurance by submitting a request to the contracted vendor on the required form, in writing, or by telephone. Contact information for the contracted vendor may be found at hca.wa.gov/employees-contact-plan.

(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), and retired employees, retired school employees, or survivors continuing PEBB health plan coverage after their employer group ceased participation (see WAC 182-12-232) 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 dependents from supplemental dependent life insurance or AD&D insurance any time during the calendar year by submitting a request to the contracted vendor on the required form, in writing, or by telephone. Contact information for the contracted vendor may be found at hca.wa.gov/employees-contact-plan.

(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 (MA) ((~~or~~)) plan, a medicare advantage-prescription drug (MA-PD) plan, or the Uniform Medical Plan (UMP) Classic medicare plan, the change in enrollment must be allowable under 42 C.F.R. Secs. 422.62(b) and 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 except for a MA ((~~or~~)) plan, a MA-PD plan, or the UMP Classic medicare plan, which will begin the first day of the month following the date the form is received.

(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.

(v) Supplemental dependent life insurance or AD&D insurance will begin 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 14 days old before supplemental dependent life insurance or AD&D insurance coverage is effective.

(b) The events described in this subsection (3)(b)(i) of this section create a special open enrollment to enroll eligible dependents in supplemental dependent life insurance or AD&D insurance. Any one of the following events may create a special open enrollment to enroll or remove eligible dependents from PEBB health plan coverage:

(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 or their dependent's 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~~)) any other 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 dependent 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, 182-12-171, 182-12-180, 182-12-211, 182-12-232, or 182-12-250. If an employee enrolls a dependent in supplemental dependent life insurance or AD&D insurance, the required form must be submitted within the required time frame described in WAC 182-08-197.

(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 60 days after the dependent becomes eligible. An employee enrolling a dependent in supplemental dependent 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 dependent 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 60 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 dependent life insurance or AD&D insurance must submit the required form to the contracted vendor for approval no later than 60 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 newly born child must be at least 14 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 26 or older as a child with a disability in PEBB health plan coverage, the required forms must be received no later than 60 days after the child reaches age 26 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 60 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~~)) MA plan, a MA-PD plan, or the UMP Classic medicare plan, the required forms must be received during a special enrollment period as allowed under 42 C.F.R. Secs. 422.62(b) and 423.38(c).

(g) An employee may enroll a dependent in supplemental dependent 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.

WSR 24-18-082
PERMANENT RULES
HEALTH CARE AUTHORITY
(Public Employees Benefits Board)
[Admin #2024-01.06—Filed August 29, 2024, 3:18 p.m., effective January 1, 2025]

Effective Date of Rule: January 1, 2025.

Purpose: The purpose of this proposal is to amend WAC 182-12-265 to support the PEBB program:

1. Implement statutory changes:

- Included language that addresses continued enrollment for a survivor of a retiree when the retiree dies to implement HB 2481, section 1, chapter 185, Laws of 2024.
- Included language that clarifies eligibility for continued enrollment in PEBB health plan coverage to implement SHB 1804, section 1, chapter 312, Laws of 2023.

2. Implement PEBB policy resolutions:

- PEBB 2024-14 Non-medicare retiree enrollment requirement.
- PEBB 2024-19 UMP classic medicare enrollment.
- PEBB 2024-20 UMP classic medicare enrollment during gap months.
- PEBB 2024-21 Amending PEBB 2022-03 medicare advantage prescription drug plan enrollment during gap months.
- PEBB 2024-26 PEBB retiree insurance coverage deferral – permanently live in a location outside of the United States.

3. Make technical amendments:

- Removed language related to Washington State Educational Service Districts.
- Added WAC 182-12-232 references that describe when a survivor who loses eligibility may continue health plan enrollment.

Citation of Rules Affected by this Order: Amending WAC 182-12-265.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.065, and 41.05.160; SHB 1804, section 1, chapter 312, Laws of 2023; HB 2481, section 1, chapter 185, Laws of 2024.

Other Authority: Policy Resolutions PEBB 2024-14, 2024-19, 2024-20, 2024-21, and 2024-26.

Adopted under notice filed as WSR 24-14-133 on July 2, 2024.

Changes Other than Editing from Proposed to Adopted Version: The subsection references in WAC 182-12-265 (2)(d) in the proposed text filed under WSR 24-14-133 are revised to WAC 182-12-205 (3)(f) and (6)(f).

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

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

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

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

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

Date Adopted: August 29, 2024.

Wendy Barcus
Rules Coordinator

OTS-5526.2

AMENDATORY SECTION (Amending WSR 23-14-015, filed 6/23/23, effective 1/1/24)

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 45 days after the election period ends as described in subsection (1), (2), or (3) of this section, except as described in WAC 182-08-180 (1)(a). 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 120 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 60 days after the later of the date of the employee's death or the date the survivor's PEBB insurance coverage ends.

Note: Enrollment in the PEBB program's medicare advantage (MA) ((~~or~~)) plan, medicare advantage-prescription drug (MA-PD) plan, or the Uniform Medical Plan (UMP) Classic medicare plan may not be retroactive.

(1) If a subscriber elects to enroll in a MA plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in a plan with the same contracted vendor during the gap month(s) prior to when the MA coverage begins.

(2) If a subscriber elects to enroll in a MA-PD plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in ((~~Uniform Medical Plan (UMP) Classic~~)) transitional coverage as designated by the director or designee during the gap month(s) prior to when the MA-PD coverage begins.

(3) If a subscriber elects to enroll in the UMP Classic medicare plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in transitional UMP coverage during the gap month(s) prior to when the UMP Classic medicare plan begins.

(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 continued enrollment in PEBB retiree insurance coverage for the surviving spouse, surviving state registered domestic partner, or surviving child of an employee of a PEBB participating employer group will cease at the end of the month in which the group's contract with the authority ends. Any survivor who loses eligibility for this reason may continue health plan enrollment as described in WAC 182-12-232.

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 as described in (a) through (d) of this subsection. ((~~The required forms to enroll or defer enrollment must be received by the PEBB program no later than 60 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 enrolled in a PEBB health plan at the time of the retiree's death, the survivors will be enrolled in the same PEBB health plan coverage they were enrolled in effective the first day of the month in which the retiree's death occurred. Eligible survivors may continue PEBB health plan coverage as described in (a) and (b) of this subsection. An eligible survivor may make changes to their PEBB health plan coverage or defer enrollment by submitting the required forms to the PEBB program. The required forms must be received no later than 60 days after the retiree's death. Changes in PEBB health plan coverage will be effective the first day of the month following the date of the retiree's death.

(d) 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 60 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 (3)(a) through (e), the survivor must also provide evidence of continuous enrollment in 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 31 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. If a retiree elected to defer enrollment in PEBB retiree insurance coverage as described in WAC 182-12-205 (3)(f), the survivor must provide proof of enrollment in medicare parts A and B; evidence of continuous enrollment in a qualified coverage is waived as described in WAC 182-12-205 (6)(f).

Note: Eligibility for continued enrollment in PEBB retiree insurance coverage 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. Any survivor who loses eligibility for this reason may continue health plan enrollment as described in WAC 182-12-232.

(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 60 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.

Note: Enrollment in the PEBB program's MA ((~~or~~)) plan, MA-PD plan, or the UMP Classic medicare plan may not be retroactive.

(1) If a subscriber elects to enroll in a MA plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in a plan with the same contracted vendor during the gap month(s) prior to when the MA coverage begins.

(2) If a subscriber elects to enroll in a MA-PD plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in ((~~UMP Classic~~)) transitional coverage as designated by the director or designee during the gap month(s) prior to when the MA-PD coverage begins.

(3) If a subscriber elects to enroll in the UMP Classic medicare plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in transitional UMP coverage during the gap month(s) prior to when the UMP Classic medicare plan begins.

(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.

Notes: 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.

Eligibility for continued enrollment in PEBB retiree insurance coverage for the surviving spouse, surviving state registered domestic partner, or surviving child of a school employee of a SEBB participating employer group will cease at the end of the month in which the group's contract with the authority ends. Any survivor who loses eligibility for this reason may continue health plan enrollment as described in WAC 182-12-232.

(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.

Exceptions: (1) If a survivor selects a medicare supplement plan ((~~or~~)), a MA-PD plan, or the UMP Classic medicare plan, nonmedicare enrollees will be enrolled in the 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.

(2) If a survivor selects a medicare supplement plan, MA-PD plan, or any other medicare plan, they may elect a PEBB vision plan available for any nonmedicare enrollees.

(6) A nonmedicare survivor must enroll in PEBB medical to be able to enroll in PEBB dental, in PEBB vision, or in both PEBB dental and PEBB vision. Any nonmedicare dependents they elect to enroll must be enrolled in the same PEBB medical, PEBB dental, and PEBB vision plan.

(7) 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 24-18-083
PERMANENT RULES
HEALTH CARE AUTHORITY
(Public Employees Benefits Board)
[Admin #2024-02—Filed August 29, 2024, 3:34 p.m., effective January 1, 2025]

Effective Date of Rule: January 1, 2025.

Purpose: The purpose of this proposal is to amend existing rules to support the PEBB program:

1. Implement PEBB policy resolutions:

- Amended WAC 182-08-187 to implement Resolution PEBB 2024-16 amending PEBB Policy Resolution "Error Correction" adopted on July 16, 2014.
- Amended WAC 182-08-196 to implement Resolution PEBB 2024-22 when a subscriber is involuntarily terminated by a medicare Part D plan.
- Amended WAC 182-08-197 to implement Resolution PEBB 2024-15 amending PEBB 2021-12 amending Resolution PEBB 2020-04 relating to default enrollments for an employee who fails to make a timely election.
- Amended WAC 182-08-199 to implement Resolution PEBB 2023-01 when a subscriber has a change in residence that affects medical plan availability.
- Amended WAC 182-12-123 to implement the new PEBB vision coverage in the following dual enrollment prohibitions related policy resolutions:
  - PEBB 2024-01 Amending PEBB 2021-02 employees may waive enrollment in medical
  - PEBB 2024-02 Amending Resolution PEBB 2021-03 PEBB benefit enrollment requirements when SEBB benefits are waived
  - PEBB 2024-03 Amending Resolution PEBB 2021-04 resolving dual enrollment when an employee's only medical enrollment is in SEBB
  - PEBB 2024-04 Amending Resolution PEBB 2021-05 resolving dual enrollment involving dual subscriber eligibility
  - PEBB 2024-05 Amending Resolution PEBB 2021-06 resolving dual enrollment involving a PEBB dependent with multiple medical enrollments
  - PEBB 2024-06 Amending Resolution PEBB 2021-07 resolving dual enrollment involving a member with multiple medical enrollments as a dependent
  - PEBB 2024-07 Amending Resolution PEBB 2021-08 PEBB benefit automatic enrollment when SEBB benefits are auto-disenrolled
  - PEBB 2024-10 Rescinding Resolution PEBB 2022-02 employees may waive enrollment in dental
- Amended WAC 182-12-128 to implement PEBB vision in the following policy resolutions:
  - PEBB 2024-01 Amending Resolution PEBB 2021-02 employees may waive enrollment in medical
  - PEBB 2024-08 Amending Resolution PEBB 2021-09 enrollment requirements when an employee loses dependent coverage in SEBB benefits
  - PEBB 2024-12 Fully insured vision plans
- Amended WAC 182-12-180 and 182-12-200 to implement the following policy resolutions regarding the new uniform medical plan (UMP) classic medicare plan with medicare Part D prescription drug coverage:

- PEBB 2024-14 Non-medicare retiree enrollment requirement
- PEBB 2024-19 UMP classic medicare enrollment
- PEBB 2024-20 UMP classic medicare enrollment during gap months
- PEBB 2024-21 Amending PEBB 2022-03 medicare advantage prescription drug plan enrollment during gap months

- Amended WAC 182-12-205 to implement the following policy resolutions:
  - PEBB 2024-11 Amending PEBB 2022-04 deferring PEBB retiree insurance coverage when the subscriber becomes eligible
  - PEBB 2024-14 Non-medicare retiree enrollment requirement
  - PEBB 2024-19 UMP classic medicare enrollment
  - PEBB 2024-20 UMP classic medicare enrollment during gap months
  - PEBB 2024-21 Amending PEBB 2022-03 medicare advantage prescription drug plan enrollment during gap months
  - PEBB 2024-26 PEBB retiree insurance coverage deferral, permanently live in a location outside of the United States.
- Amended WAC 182-12-250 to implement the following policy resolutions:
  - PEBB 2024-14 Non-Medicare retiree enrollment requirement
  - PEBB 2024-20 UMP Classic Medicare enrollment during gap months
  - PEBB 2024-21 Amending PEBB 2022-03 Medicare Advantage Prescription Drug plan enrollment during gap months
  - PEBB 2024-26 PEBB retiree insurance coverage deferral, permanently live in a location outside of the United States. (Note: This explanation for WAC 182-12-250 was inadvertently left off the proposed rule making (CR-102) under purpose but the proposed section was included in the proposed text filed under WSR 24-14-122.)

2. Make technical amendments:

- Amended WAC 182-08-187 to include a subsection reference when there is a failure to enroll an employee and their dependents in PEBB benefits, revised supplemental life insurance and supplemental accidental death and dismemberment insurance enrollment information by including other WAC references, and clarified recourse for an employee who establishes eligibility and regains eligibility for the employer contribution toward PEBB benefits.
- Amended WAC 182-08-196 to include UMP classic medicare plan and medicare Part D plan.
- Amended WAC 182-08-197 to include PEBB vision, and updated subsection references and flexible spending arrangement (FSA).
- Amended WAC 182-08-199 to update FSA and to include special open enrollment events regarding a change in residence and when the PEBB program determines that there has been a substantial decrease in the providers available under a PEBB medical plan.
- Amended WAC 182-12-128 to update a subsection reference.
- Amended WAC 182-12-180 to add an exception and update reference, to remove language regarding Washington State Educational Service District, and to add UMP classic medicare plan.

Citation of Rules Affected by this Order: Amending WAC 182-08-187, 182-08-196, 182-08-197, 182-08-199, 182-12-123, 182-12-128, 182-12-180, 182-12-200, 182-12-205, and 182-12-250.

Statutory Authority for Adoption: RCW 41.05.021, 41.06.065 [41.05.065], and 41.05.160.

Other Authority: PEBB resolutions.

Adopted under notice filed as WSR 24-14-122 on July 2, 2024.

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

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

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 10, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 10, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 10, Repealed 0.

Date Adopted: August 29, 2024.

Wendy Barcus
Rules Coordinator

OTS-5535.1

AMENDATORY SECTION (Amending WSR 23-14-017, filed 6/23/23, effective 1/1/24)

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) or (3)(c);

(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, and vision enrollment is effective 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;

Exception: When an employee who is called to active duty in the uniformed services under Uniformed Services Employment and Reemployment Rights Act (USERRA) loses eligibility for the employer contribution toward PEBB benefits, they regain eligibility for the employer contribution toward PEBB benefits the day they return from active duty. Employer-paid PEBB benefits will begin the first day of the month in which they return from active duty.

(b) Basic life, supplemental life insurance, basic accidental death and dismemberment (AD&D), supplemental AD&D, 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, employer-paid LTD insurance, and employee-paid LTD insurance begin on that date;~~

~~Exception:~~ ~~When an employee who is called to active duty in the uniformed services under USERRA loses eligibility for the employer contribution toward PEBB benefits, they regain eligibility for the employer contribution toward PEBB benefits the day they return from active duty. Employer-paid PEBB benefits will begin the first day of the month in which they return from active duty.~~

~~(c) Supplemental life, supplemental AD&D, and 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 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 employee-paid LTD insurance during the period of leave as described in WAC 182-12-133, 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 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)~~)) will begin for a newly eligible employee as described in WAC 182-12-114 and for an employee regaining eligibility as described in WAC 182-08-197(3). An employee who regains eligibility may need to submit evidence of insurability for supplemental life insurance or employee-paid LTD insurance as required in WAC 182-08-197(3).

(c) If the employee is eligible and elects (or elected) to enroll in the ((~~medical~~)) flexible spending arrangement (FSA), limited purpose FSA, or dependent care assistance program (DCAP), enrollment is limited to 60 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, limited purpose 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;

((~~(c)~~)) (d) 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 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 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 24 months of coverage. The employing agency is responsible for additional months of premiums.

(ii) When a premium refund is due to the employee, the LTD insurance contracted vendor is responsible for premium refunds for the most recent 24 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~~)) An employee who establishes eligibility will have benefits begin as described in WAC 182-12-114. An employee who regains eligibility for the employer contribution toward PEBB benefits will have benefits begin as described in WAC 182-08-197(3). 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)((~~,~~)) and (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, and vision 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 23-14-016, filed 6/23/23, effective 1/1/24)

WAC 182-08-196 What happens if my health plan becomes unavailable? (1) A subscriber must elect a new health plan when their previously selected health plan becomes unavailable due to a change in contracting service area as described below:

(a) When a health plan becomes unavailable during the plan year, a subscriber must elect a new health plan no later than 60 days after the date their previously selected health plan becomes unavailable.

(i) An employee must submit the required forms to their employing agency electing their new health plan.

(ii) Any other subscriber must submit the required forms to the PEBB program electing their new health plan.

(iii) The effective date of the change in health plan will be the first day of the month following the later of the date the health plan becomes unavailable or the date the form is received. If that day is the first of the month, the change in health plan begins on that day.

(b) When a health plan becomes unavailable at the beginning of the next plan year, a subscriber must elect a new health plan no later than the last day of the public employees benefits board (PEBB) annual open enrollment.

(i) An employee must submit the required forms to their employing agency electing their new health plan.

(ii) Any other subscriber must submit the required forms to the PEBB program electing their new health plan.

(iii) The effective date of the change in health plan will be January 1st of the following year.

(c) A subscriber who fails to elect a new health plan within the required time period as required in (a) or (b) of this subsection will be enrolled in a health plan designated by the director or designee.

(2) A subscriber must elect a new health plan when their previously selected health plan becomes unavailable due to the subscriber or subscriber's dependent ceasing to be eligible for their current health plan because of enrollment in medicare as described below:

(a) The required forms electing a new health plan must be received no later than 60 days after the date their previously selected health plan becomes unavailable.

Exception: The required forms electing a new medicare advantage (MA) ((~~or~~)) plan, medicare advantage-prescription drug (MA-PD) plan, or the Uniform Medical Plan (UMP) Classic medicare plan must be received no later than two months after the date their previously selected health plan becomes unavailable.

(i) An employee must submit the required forms to their employing agency electing their new health plan.

(ii) Any other subscriber must submit the required forms to the PEBB program electing their new health plan.

(iii) The effective date of the change in health plan will be the first day of the month following the later of the date the health plan becomes unavailable or the date the form is received. If that day is the first of the month, the change in health plan begins on that day except for a MA ((~~or~~)) plan, MA-PD plan, or the UMP Classic medicare

plan which will begin the first day of the month following the date the form is received.

(b) A subscriber who is enrolled in a consumer directed health plan (CDHP) with a health savings account (HSA), and fails to elect a new health plan within the required time period as required in this subsection, will not be eligible to receive contributions to the HSA. A subscriber will be liable for any tax penalties resulting from contributions made when they are no longer eligible.

(3) A subscriber must elect a new medical plan when their previously selected medical plan becomes unavailable due to a change in their residence as described below.

(a) When a subscriber's medical plan becomes unavailable during the plan year, a subscriber must elect a new medical plan no later than 60 days after the date their previously selected medical plan becomes unavailable as described in WAC 182-08-198 (2)(e).

(i) An employee must submit the required forms to their employing agency electing their new medical plan.

(ii) Any other subscriber must submit the required forms to the PEBB program electing their new medical plan.

(iii) The effective date of the change in medical plan will be the first day of the month following the later of the date the medical plan becomes unavailable or the date the form is received. If that day is the first of the month, the change in medical plan begins on that day except for a MA ((~~or~~)) plan, a MA-PD plan, or the UMP Classic medicare plan which will begin the first day of the month following the date the form is received.

(b) A subscriber who fails to elect a new medical plan within the required time period as required in (a) of this subsection will be enrolled in a public employees benefits board medical plan designated by the director or designee.

(4) When a subscriber or their dependent must be disenrolled by a MA ((~~or~~)) plan, MA-PD plan, or a medicare Part D plan as required by federal law, the subscriber and their enrolled dependents will be enrolled in a PEBB medical plan as designated by the director or designee. The new medical plan coverage will begin the first day of the month following the date the MA ((~~or~~)) plan, the MA-PD plan, or the UMP Classic medicare plan is terminated.

(5) A subscriber enrolled in a health plan as described in subsection (1)(c), (2)(b), (3)(b), or (4) of this section may not change health plans except as allowed in WAC 182-08-198.

AMENDATORY SECTION (Amending WSR 23-14-015, filed 6/23/23, effective 1/1/24)

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 enrollment provided the employee is eligible 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 31 days after the employee becomes eligible for PEBB benefits under WAC 182-12-114.

(i) An employee may enroll in supplemental life 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 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 31 days after the employee becomes eligible for PEBB benefits.

(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), limited purpose FSA, dependent care assistance program (DCAP), or both an FSA and DCAP, 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 31 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, vision, life insurance, AD&D insurance, and LTD insurance elections, and the employee's tobacco use status attestation within 31 days of the employee becoming eligible, their enrollment will be as follows for those elections not received within 31 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;

((~~(iv)~~)) (v) Basic AD&D insurance;

((~~(v)~~)) (vi) Employer-paid LTD insurance and employee-paid LTD insurance;

((~~(vi)~~)) (vii) Dependents will not be enrolled; and

((~~(vii)~~)) (viii) 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, and vision 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).

Note: When an employee who is called to active duty in the uniformed services under Uniformed Services Employment and Reemployment Rights Act (USERRA) loses eligibility for the employer contribution toward PEBB benefits, they regain eligibility for the employer contribution toward PEBB benefits the day they return from active duty. Employer-paid PEBB benefits will begin the first day of the month in which they return from active duty.

(a) An employee must complete the required forms indicating their enrollment elections, including an election to waive enrollment if the employee chooses to waive 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 31 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 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 employee-paid LTD insurance but discontinued that coverage must submit evidence of insurability for 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 employee-paid LTD insurance elections. Their 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 employee-paid LTD insurance after losing eligibility for the employer contribution;

(ii) The employee was not eligible to continue 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 31 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)~~)) (viii) 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, limited purpose FSA, DCAP, or both an FSA and DCAP, 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 31 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 a DCAP, a ((~~medical~~)) FSA, or a limited purpose FSA until the beginning of the next plan year, unless the time between employments is 30 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 31 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.

(6) When a retiree becomes eligible for the employer contribution toward PEBB benefits, PEBB retiree insurance coverage will be automatically deferred. The subscriber will be exempt from the deferral form requirement.

Note: When the subscriber is no longer eligible for the employer contribution toward PEBB benefits, they may enroll in PEBB retiree insurance coverage as described in WAC 182-12-171, or continue in a deferred status if they meet the requirements in WAC 182-12-200 or 182-12-205.

AMENDATORY SECTION (Amending WSR 23-14-015, filed 6/23/23, effective 1/1/24)

WAC 182-08-199 When may an employee enroll, or revoke an election and make a new election under the premium payment plan, ((~~medical~~)) flexible spending arrangement (FSA), limited purpose FSA, or dependent care assistance program (DCAP)? An employee who is eligible to participate in the salary reduction plan as described in WAC 182-12-116 may enroll, or revoke their election and make a new election under the premium payment plan, ((~~medical~~)) flexible spending arrangement (FSA), limited purpose FSA, or dependent care assistance program (DCAP) at the following times:

(1) When newly eligible under WAC 182-12-114 and enrolling as described in WAC 182-08-197(1).

(2) **During annual open enrollment:** An eligible employee may elect to enroll in or opt out of participation under the premium payment plan during the annual open enrollment by submitting the required form to their employing agency. An eligible employee may elect to enroll or reenroll in the ((~~medical~~)) FSA, limited purpose FSA, DCAP, or both an FSA and DCAP during the annual open enrollment by submitting the required forms to their employing agency or applicable contracted vendor

as instructed. All required forms must be received no later than the last day of the annual open enrollment. The enrollment or new election becomes effective January 1st of the following year.

(a) Employees cannot enroll in a ((~~medical~~)) FSA and a limited purpose FSA in the same year.

(b) Employees enrolled in a consumer directed health plan (CDHP) with a health savings account (HSA) cannot also enroll in a ((~~medical~~)) FSA in the same plan year. Employees who elect enrollment in the CDHP with a HSA and a ((~~medical~~)) FSA will only be enrolled in a CDHP with a HSA.

(c) Employees who enroll in a CDHP with a HSA during the annual open enrollment and have a carryover amount from a ((~~medical~~)) FSA, will be enrolled in a limited purpose FSA and the carryover amount will be deposited into the limited purpose FSA.

(d) Employees who are not enrolled in a CDHP with a HSA and elect both a ((~~medical~~)) FSA and a limited purpose FSA will be enrolled in the ((~~medical~~)) FSA.

(3) **During a special open enrollment:** An employee who is eligible to participate in the salary reduction plan may enroll or revoke their election and make a new election under the premium payment plan, ((~~medical~~)) FSA, limited purpose FSA, or DCAP outside of the annual open enrollment if a special open enrollment event occurs. The enrollment or change in election must be allowable under Internal Revenue Code (IRC) and Treasury regulations, and correspond to and be consistent with the event that creates the special open enrollment. To make a change or enroll, the employee must submit the required form to their employing agency. The employing agency must receive the required form and evidence of the event that created the special open enrollment no later than 60 days after the event occurs.

For purposes of this section, an eligible dependent includes any person who qualifies as a dependent of the employee for tax purposes under IRC 26 U.S.C. Sec. 152 without regard to the income limitations of that section. It does not include a state registered domestic partner unless the state registered domestic partner otherwise qualifies as a dependent for tax purposes under IRC 26 U.S.C. Sec. 152.

(a) **Premium payment plan.** An employee may enroll or revoke their election and elect to opt out of the premium payment plan when any of the following special open enrollment events occur, if the requested change corresponds to and is consistent with the event. The enrollment or election to opt out will be effective the first day of the month following the later of the event date or the date the required form is received. If that day is the first of the month, the enrollment or change in election begins on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, the enrollment or change in election will begin the first of the month in which the event occurs.

(i) Employee acquires a new dependent due to:

• Marriage;

• Registering a state registered domestic partnership when the dependent is a tax dependent of the employee;

• Birth, adoption, or when the employee has assumed a legal obligation for total or partial support in anticipation of adoption; or

• A child becoming eligible as an extended dependent through legal custody or legal guardianship.

(ii) Employee's dependent no longer meets public employee benefits board (PEBB) eligibility criteria because:

• Employee has a change in marital status;

• Employee's domestic partnership with a state registered domestic partner who is a tax dependent is dissolved or terminated;

• An eligible dependent child turns age 26 or otherwise does not meet dependent child eligibility criteria;

• An eligible dependent ceases to be eligible as an extended dependent or as a dependent with a disability; or

• An eligible dependent dies.

(iii) Employee or an employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);

(iv) Employee has a change in employment status that affects the employee's eligibility for their employer contribution toward their employer-based group health plan;

(v) The employee's dependent has a change in their own employment status that affects their eligibility or their dependent's eligibility for the employer contribution under their employer-based group health plan;

Note: As used in (a)(v) of this subsection, "employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 26 C.F.R. 54.9801-6.

(vi) Employee or an employee's dependent has a change in enrollment under an employer-based group health plan during its annual open enrollment that does not align with the PEBB annual open enrollment;

(vii) Employee or an employee's dependent has a change in residence that affects health plan availability. If the employee has a change in residence and the employee's current medical plan is no longer available, the employee must select a new medical plan as described in WAC 182-08-196(3);

(viii) Employee's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States and that change in residence resulted in the dependent losing their health insurance;

(ix) A court order requires the employee or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state registered domestic partner is not an eligible dependent);

(x) Employee or an employee's dependent enrolls in coverage under medicaid or a state children's health insurance program (CHIP), or the subscriber or a subscriber's dependent loses eligibility for coverage under medicaid or CHIP;

(xi) Employee or an employee's dependent becomes eligible for state premium assistance subsidy for PEBB medical plan coverage from medicaid or CHIP;

(xii) Employee or an employee's dependent enrolls in coverage under medicare or the employee or an employee's dependent loses eligibility for coverage under medicare;

(xiii) Employee or an employee's dependent's current medical plan becomes unavailable because the employee or enrolled dependent is no longer eligible for a health savings account (HSA). The health care authority (HCA) requires evidence that the employee or employee's dependent is no longer eligible for an HSA;

(xiv) Employee or an employee's dependent experiences a disruption of care for active and ongoing treatment, that could function as a reduction in benefits for the employee or the employee's dependent. The employee may not change their health plan election if the employee's or dependent's physician stops participation with the employee's

health plan unless the PEBB program determines that a continuity of care issue exists. The PEBB program will consider but not limit its consideration to the following:

• Active cancer treatment such as chemotherapy or radiation therapy;

• Treatment following a recent organ transplant;

• A scheduled surgery;

• Recent major surgery still within the postoperative period; or

• Treatment for a high-risk pregnancy.

(xv) Employee or employee's dependent becomes eligible and enrolls in a TRICARE plan, or loses eligibility for a TRICARE plan;

(xvi) The PEBB program determines that there has been a substantial decrease in the providers available under a PEBB medical plan.

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

(b) **((~~Medical~~)) FSA and limited purpose FSA.** An employee may enroll or revoke their election and make a new election under the ((~~medical~~)) FSA or limited purpose FSA when any one of the following special open enrollment events occur, if the requested change corresponds to and is consistent with the event. The enrollment or new election will be effective the first day of the month following the later of the event date or the date the required form and evidence of the event that created the special open enrollment is received by the employing agency. If that day is the first of the month, the enrollment or change in election begins on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, the enrollment or change in election will begin the first of the month in which the event occurs.

(i) Employee acquires a new dependent due to:

• Marriage;

• Registering a state registered domestic partnership if the domestic partner qualifies as a tax dependent of the employee;

• Birth, adoption, or when the employee has assumed a legal obligation for total or partial support in anticipation of adoption; or

• A child becoming eligible as an extended dependent through legal custody or legal guardianship.

(ii) Employee's dependent no longer meets PEBB eligibility criteria because:

• Employee has a change in marital status;

• Employee's domestic partnership with a state registered domestic partner who qualifies as a tax dependent is dissolved or terminated;

• An eligible dependent child turns age 26 or otherwise does not meet dependent child eligibility criteria;

• An eligible dependent ceases to be eligible as an extended dependent or as a dependent with a disability; or

• An eligible dependent dies.

(iii) Employee or an employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the HIPAA;

(iv) Employee or an employee's dependent has a change in employment status that affects the employee's or a dependent's eligibility for the ((~~medical~~)) FSA or limited purpose FSA;

(v) A court order requires the employee or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state registered domestic partner is not an eligible dependent);

(vi) Employee or an employee's dependent enrolls in coverage under medicaid or a state children's health insurance program (CHIP), or the employee or an employee's dependent loses eligibility for coverage under medicaid or CHIP;

(vii) Employee or an employee's dependent enrolls in coverage under medicare.

(c) **DCAP.** An employee may enroll or revoke their election and make a new election under the DCAP when any one of the following special open enrollment events occur, if the requested change corresponds to and is consistent with the event. The enrollment or new election will be effective the first day of the month following the later of the event date or the date the required form and evidence of the event that created the special open enrollment is received by the employing agency. If that day is the first of the month, the enrollment or change in election begins on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, the enrollment or change in election will begin the first of the month in which the event occurs.

(i) Employee acquires a new dependent due to:

• Marriage;

• Registering a state registered domestic partnership if the domestic partner qualifies as a tax dependent of the employee;

• Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or

• A child becoming eligible as an extended dependent through legal custody or legal guardianship.

(ii) Employee or an employee's dependent has a change in employment status that affects the employee's or a dependent's eligibility for DCAP;

(iii) Employee or an employee's dependent has a change in enrollment under an employer-based DCAP during its annual open enrollment that does not align with the PEBB annual open enrollment;

(iv) Employee changes dependent care provider; the change to the DCAP election amount can reflect the cost of the new provider;

(v) Employee or the employee's spouse experiences a change in the number of qualifying individuals as defined in IRC 26 U.S.C. Sec. 21 (b)(1);

(vi) Employee's dependent care provider imposes a change in the cost of dependent care; employee may make a change in the DCAP election amount to reflect the new cost if the dependent care provider is not a qualifying relative of the employee as defined in IRC 26 U.S.C. Sec. 152.

OTS-5536.2

AMENDATORY SECTION (Amending WSR 23-14-015, filed 6/23/23, effective 1/1/24)

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, 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 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, and PEBB vision 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, or PEBB vision 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 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, and vision 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, and PEBB vision 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, and a single enrollment in PEBB vision.

(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 60 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 em-

ploying 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. An employee must elect to enroll in PEBB benefits as described in WAC 182-08-197, waive enrollment as described in WAC 182-12-128, or remove eligible dependents as described in WAC 182-12-262. If the employee 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 ((~~(d) through (h)~~)) (c) through (g) of 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 and PEBB vision.

(b) ((~~An eligible employee who waives enrollment in PEBB medical when they are enrolled in other employer-based group medical, a TRICARE plan, or medicare as described in WAC 182-12-128, and are not enrolled in SEBB medical, may waive enrollment in PEBB dental only if they are enrolled in both SEBB dental and SEBB vision as an eligible dependent in the SEBB program.~~

~~(c)~~)) 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 and PEBB vision. If the school employee is not already enrolled in PEBB dental((~~,~~)) and PEBB vision the PEBB program will automatically enroll the school employee in the associated subscriber's PEBB dental and PEBB vision.

((~~(d)~~)) (c) If the employee is enrolled only in PEBB dental and PEBB vision, 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 and PEBB vision in which they are enrolled. If the employee is not already enrolled in SEBB dental or SEBB vision, the SEBB program will automatically enroll them in both as described in WAC 182-31-070 (6)(g). The employee's enrollment in PEBB program life insurance, accidental death and dismemberment (AD&D) insurance, and long-term disability (LTD) insurance will remain.

((~~(c)~~)) (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, and PEBB vision. The employee's enrollment in PEBB program life insurance, AD&D insurance, and LTD insurance will remain. If the employee is not enrolled in any medical under either the PEBB or SEBB program but is enrolled ((~~only~~)) in PEBB dental, PEBB vision, SEBB dental, and SEBB vision ((~~(with or without enrollment in SEBB dental)~~)), the employee will remain in SEBB ((~~vision and if enrolled, SEBB dental. If the employee is not already enrolled in SEBB dental, the SEBB program will automatically enroll them as described in WAC 182-31-070 (6)(g)~~)) benefits. The PEBB program will automatically disenroll the employee from PEBB dental and PEBB vision.

((~~(f)~~)) (e) If the employee's dependent is enrolled in any PEBB medical ((~~or~~)), PEBB dental, or PEBB vision 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, and PEBB vision in which they are enrolled.

((~~(g)~~)) (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, and PEBB vision 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)~~)) in both a PEBB and SEBB dental plan, PEBB and SEBB vision plan, or any combination of these coverages as a dependent, the dependent will remain in SEBB ((~~vision and if enrolled, SEBB dental~~)) benefits. The PEBB program will automatically disenroll the employee's dependent from PEBB ((~~dental~~)) benefits.

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.

((~~(h)~~)) (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 and PEBB vision, if they are not already enrolled.

((~~(i)~~)) (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).

((~~(j)~~)) (i) If the PEBB program automatically disenrolls an individual from PEBB medical ((~~or~~)), PEBB dental, or PEBB vision to resolve their dual enrollment as described in ((~~(e), (f), or (g)~~)) (d), (e), or (f) of this subsection, but later determines that the employee did take action to resolve their dual enrollment within the required timelines, the PEBB program will reinstate coverage retroactive to the first of the month in which the individual was disenrolled.

(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 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 23-14-015, filed 6/23/23, effective 1/1/24)

WAC 182-12-128 When may an employee waive enrollment in public employees benefits board (PEBB) medical and when may they enroll in PEBB medical after having waived enrollment? An employee may waive

enrollment in public employees benefits board (PEBB) medical if they are enrolled in other employer-based group medical, a TRICARE plan, or medicare as described in subsection (1)(a) through (c) of this section. They may not waive enrollment in PEBB medical if they are enrolled in PEBB retiree insurance coverage. An employee who waives enrollment in PEBB medical must enroll in PEBB dental, PEBB vision, basic life insurance, basic accidental death and dismemberment insurance, and 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 and PEBB vision.

(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 31 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 60 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 an-

nual 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 60 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, and PEBB vision. If the employee's employing agency does not receive the employee's required forms indicating their medical ((~~and~~)), dental, and vision elections within 60 days of the employee losing SEBB medical, SEBB dental, and SEBB vision, they will be defaulted into employee-only PEBB medical ((~~and~~)), PEBB dental, and PEBB vision as described in WAC 182-08-197 (1)(b)(i) ((~~and (ii)~~)) 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 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 or their dependent's 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 22-13-160, filed 6/21/22, effective 1/1/23)

WAC 182-12-180 When is an elected and full-time appointed official of the legislative and executive branch of state government, or their survivor eligible to continue enrollment in public employees benefits board (PEBB) retiree insurance coverage? (1) An elected and full-time appointed official of the legislative and executive branch of state government is eligible to continue enrollment or defer enrollment in public employees benefits board (PEBB) retiree insurance coverage under the same terms as an outgoing legislator, when they voluntarily or involuntarily leave public office. The following officials are eligible if they meet the procedural requirements as described in subsection (3) of this section:

(a) A member of the state legislature;

(b) A statewide elected official of the executive branch;

(c) An executive official appointed directly by the governor as the single head of an executive branch agency; or

(d) An official appointed directly by a state legislative committee as the single head of a legislative branch agency or an official

appointed to secretary of the senate or chief clerk of the house of representatives.

(2) The spouse, state registered domestic partner, or child of an official described in subsection (1) of this section who loses eligibility due to the death of the official may enroll as a survivor under PEBB retiree insurance coverage as described in (a) and (b) of this subsection and must meet procedural requirements to enroll or defer enrollment as described in subsection (3) of this section.

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

(b) The official's child may continue health plan enrollment until they lose eligibility as described in WAC 182-12-260.

(3) **Procedural requirements.** An official described in subsection (1) of this section or their survivor described in subsection (2) of this section must enroll or defer enrollment in PEBB retiree insurance coverage as described in (a) through ((~~(d)~~)) (e) of this subsection:

(a) For an official to enroll in PEBB retiree insurance coverage the required forms must be received by the PEBB program no later than 60 days after the official leaves public office. The effective date of PEBB retiree insurance coverage is the first day of the month after the official leaves public office;

For a survivor to enroll in PEBB retiree insurance coverage, the required forms must be received by the PEBB program no later than 60 days after the later of the date of the official's death or the date the survivor's PEBB insurance coverage ends. The effective date of PEBB retiree insurance coverage is the first day of the month after the date of the official's death or the first day of the month after the survivor's PEBB insurance coverage ends;

Note: Enrollment in the PEBB program's medicare advantage (MA) ((~~or~~)) plan, medicare advantage-prescription drug (MA-PD) plan, or the Uniform Medical Plan (UMP) Classic medicare plan may not be retroactive.
(1) If a subscriber elects to enroll in a MA plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in a plan with the same contracted vendor during the gap month(s) prior to when the MA coverage begins.
(2) If a subscriber elects to enroll in a MA-PD plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in ((~~Uniform Medical Plan (UMP) Classic~~)) transitional coverage as designated by the director or designee during the gap month(s) prior to when the MA-PD coverage begins.
(3) If a subscriber elects to enroll in the UMP Classic medicare plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in transitional UMP coverage during the gap month(s) prior to when the UMP Classic medicare plan begins.

(b) The official's or survivor's first premium payment and applicable premium surcharges are due to the health care authority (HCA) no later than 45 days after the official's or survivor's election period ends as described in (a) of this subsection, except as described in WAC 182-08-180 (1)(a). Following the official's or survivor's first premium payment, premiums and applicable premium surcharges must be paid as described in WAC 182-08-180 (1)(c);

(c) If an official or a survivor elects to enroll a dependent in PEBB health plan coverage, the dependent must be enrolled in the same PEBB medical and PEBB dental plan as the official or survivor;

Exceptions: (1) If an official or a survivor selects a medicare supplement plan ((~~or~~)), a MA-PD plan, or the UMP Classic medicare plan, nonmedicare enrollees will be enrolled in the UMP Classic. If an official or a survivor selects any other medicare plan, they must also select a nonmedicare plan with the same contracted vendor available to nonmedicare enrollees.
(2) If the official or survivor selects a medicare supplement plan, MA-PD plan, or any other medicare plan, they may elect a PEBB vision plan available for any nonmedicare enrollees.

(d) An official or survivor who is nonmedicare must enroll in PEBB medical to be able to enroll in PEBB dental, in PEBB vision, or in both dental and vision. Any nonmedicare dependents they elect to enroll must be enrolled in the same PEBB medical, PEBB dental, and PEBB vision plan.

(e) To defer enrollment in PEBB retiree insurance coverage the official or the survivor must meet deferral enrollment requirements as described in WAC 182-12-200 or 182-12-205.

(4) If the official, an enrolled dependent, or their survivor is eligible for medicare or becomes eligible for medicare after enrollment in PEBB retiree insurance coverage, they must enroll and maintain enrollment in medicare Parts A and B to remain enrolled in a PEBB retiree health plan. If an enrollee who is eligible for medicare does not meet this procedural requirement, the enrollee is no longer eligible for enrollment in a PEBB retiree health plan. The enrollee's eligibility will end as described in the termination notice sent by the PEBB program. The enrollee may continue PEBB health plan enrollment as described in WAC 182-12-146.

Note: For the exclusive purpose of medicare Part A as described in this subsection, "eligible" means the enrollee is eligible for medicare Part A without a monthly premium.

(5) An official described in subsection (1) of this section shall be included in the term "retiree" or "retiring employee" as used in chapters 182-08, 182-12, and 182-16 WAC.

AMENDATORY SECTION (Amending WSR 23-14-015, filed 6/23/23, effective 1/1/24)

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) 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 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, and PEBB vision. A retiree must be enrolled in PEBB medical to enroll in PEBB dental except for a nonmedicare retiree must enroll in PEBB medical to be able to enroll in PEBB dental, in PEBB vision, or in both PEBB dental and PEBB vision. 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 by submitting the required forms as described below and evidence of continuous enrollment in a health plan sponsored by PEBB or SEBB. Evidence of continuous enrollment in a health plan sponsored by a Washington state educational service district may be required if a retiring employee, a retiring school employee, or a retiree deferred enrollment under this section prior to January 1, 2024. A gap of 31 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 60 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.

Note: Enrollment in the PEBB program's medicare advantage (MA) ((~~or~~)) plan, medicare advantage-prescription drug (MA-PD) plan, or the Uniform Medical Plan (UMP) Classic medicare plan may not be retroactive.
(1) If a subscriber elects to enroll in a MA plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in a plan with the same contracted vendor during the gap month(s) prior to when the MA coverage begins.
(2) If a subscriber elects to enroll in a MA-PD plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in ((~~Uniform Medical Plan (UMP) Classic~~)) transitional coverage as designated by the director or designee during the gap month(s) prior to when the MA-PD coverage begins.
(3) If a subscriber elects to enroll in the UMP Classic medicare plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in transitional UMP coverage during the gap month(s) prior to when the UMP Classic medicare plan begins.

(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.

Exceptions: (1) If a retiree selects a medicare supplement plan ((~~or~~)), a MA-PD plan, or the UMP Classic medicare plan, nonmedicare enrollees will be enrolled in the 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.
(2) If a retiree selects a medicare supplement plan, MA-PD plan, or any other medicare plan, they may elect a PEBB vision plan available for any nonmedicare enrollees.

(d) A nonmedicare retiree must enroll in PEBB medical to be able to enroll in PEBB dental, in PEBB vision, or in both PEBB dental and PEBB vision. Any nonmedicare dependents they elect to enroll must be enrolled in the same PEBB medical, PEBB dental, and PEBB vision plan.

AMENDATORY SECTION (Amending WSR 23-14-015, filed 6/23/23, effective 1/1/24)

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) When a subscriber described in subsection (1) of this section ((~~who~~)) chooses to defer enrollment in PEBB retiree insurance coverage as described in (a) through (e) of this subsection, they must maintain

continuous enrollment in one or more qualifying coverages as described in (a) through (e) of this subsection or WAC 182-12-200. A gap of 31 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. When a subscriber chooses to defer enrollment in PEBB retiree insurance coverage as described in (f) of this subsection; evidence of continuous enrollment in a qualified coverage is waived as described in subsection (6)(f) of this section.

A subscriber who chooses to defer enrollment, defers enrollment in PEBB medical ((~~and~~)), PEBB dental, and PEBB vision. A subscriber must be enrolled in PEBB medical to enroll in PEBB dental except for a nonmedicare retiree must enroll in PEBB medical to be able to enroll in PEBB dental, in PEBB vision, or in both PEBB dental and PEBB vision. 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).

(f) Beginning January 1, 2025, subscribers who are enrolled in medicare may defer enrollment in PEBB retiree insurance coverage when they permanently live in a location outside of the United States.

(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 own employer-paid coverage, COBRA coverage, or continuation coverage ends. The forms must be received by the PEBB program no later than 60 days after their own 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 60 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 60 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 60 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 60 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 60 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 180 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 (MA), then~~)) (MA) plan, a medicare advantage-prescription drug (MA-PD) plan, or the Uniform Medical Plan (UMP) Classic medicare plan, the enrollment in PEBB retiree insurance coverage will be deferred effective the first of the month following the date the ((~~MA~~)) plan disenrollment form is received.

(5) A retiree who meets substantive eligibility requirements in WAC 182-12-171(2) and whose own employer-paid coverage, COBRA coverage, or continuation coverage ended between January 1, 2001, and December 31, 2001, was not required to have submitted the deferral form at that time, but must meet all procedural requirements as stated in this section, WAC 182-12-171, and 182-12-200.

(6) A subscriber described in subsection (1) of this section who defers enrollment ((~~while enrolled in qualifying coverage~~)) as described in subsection (3)(a) through ((~~(e)~~)) (f) of this section may later enroll themselves and their dependents in a PEBB health plan by submitting the required forms as described below ((~~and~~)). A subscriber who defers enrollment as described in subsection (3)(a) through (e) of

this section must provide evidence of continuous enrollment in one or more qualifying coverages as described in subsection (3)(a) through (e) of this section. A gap of 31 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 defers enrollment as described in subsection (3)(f) of this section must provide proof of enrollment in medicare parts A and B; evidence of continuous enrollment in a qualified coverage is waived as described in (f) of this subsection:

(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 60 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.

Note: Enrollment in the PEBB program's MA ((~~or medicare advantage prescription drug (MA-PD)~~)) plan, MA-PD plan, or the UMP Classic medicare plan may not be retroactive.
(1) If a subscriber elects to enroll in a MA plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in a plan with the same contracted vendor during the gap month(s) prior to when the MA coverage begins.
(2) If a subscriber elects to enroll in a MA-PD plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in ((~~Uniform Medical Plan (UMP) Classic~~)) transitional coverage as designated by the director or designee during the gap month(s) prior to when the MA-PD coverage begins.
(3) If a subscriber elects to enroll in the UMP Classic medicare plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in transitional UMP coverage during the gap month(s) prior to when the UMP Classic medicare plan begins.

(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 60 days after coverage ends. PEBB health plan coverage begins the first day of the month after coverage under the federal retiree medical plan ends.

Note: Enrollment in the PEBB program's MA ((~~or~~)) plan, MA-PD plan, or the UMP Classic medicare plan may not be retroactive.
(1) If a subscriber elects to enroll in a MA plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in a plan with the same contracted vendor during the gap month(s) prior to when the MA coverage begins.
(2) If a subscriber elects to enroll in a MA-PD plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in ((~~UMP Classic~~)) transitional coverage as designated by the director or designee during the gap month(s) prior to when the MA-PD coverage begins.
(3) If a subscriber elects to enroll in the UMP Classic medicare plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in transitional UMP coverage during the gap month(s) prior to when the UMP Classic medicare plan begins.

(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 60 days after coverage ends. PEBB health plan coverage begins the first day of the month after the medicaid coverage ends; or

Note: Enrollment in the PEBB program's MA ((~~or~~)) plan, MA-PD plan, or the UMP Classic medicare plan may not be retroactive.
(1) If a subscriber elects to enroll in a MA plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in a plan with the same contracted vendor during the gap month(s) prior to when the MA coverage begins.
(2) If a subscriber elects to enroll in a MA-PD plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in ((~~UMP Classic~~)) transitional coverage as designated by the director or designee during the gap month(s) prior to when the MA-PD coverage begins.
(3) If a subscriber elects to enroll in the UMP Classic medicare plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in transitional UMP coverage during the gap month(s) prior to when the UMP Classic medicare plan begins.

(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 60 days after coverage ends. PEBB health plan coverage begins the first day of the month after exchange coverage ends.

Note: Enrollment in the PEBB program's MA ((~~or~~)) plan, MA-PD plan, or the UMP Classic medicare plan may not be retroactive.
(1) If a subscriber elects to enroll in a MA plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in a plan with the same contracted vendor during the gap month(s) prior to when the MA coverage begins.
(2) If a subscriber elects to enroll in a MA-PD plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in ((~~UMP Classic~~)) transitional coverage as designated by the director or designee during the gap month(s) prior to when the MA-PD coverage begins.
(3) If a subscriber elects to enroll in the UMP Classic medicare plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in transitional UMP coverage during the gap month(s) prior to when the UMP Classic medicare plan begins.

(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 60 days after coverage ends. PEBB health plan coverage begins the first day of the month after CHAMPVA coverage ends.

Note: Enrollment in the PEBB program's MA ((or)) plan, MA-PD plan, or the UMP Classic medicare plan may not be retroactive.
(1) If a subscriber elects to enroll in a MA plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in a plan with the same contracted vendor during the gap month(s) prior to when the MA coverage begins.
(2) If a subscriber elects to enroll in a MA-PD plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in ((UMP Classic)) transitional coverage as designated by the director or designee during the gap month(s) prior to when the MA-PD coverage begins.
(3) If a subscriber elects to enroll in the UMP Classic medicare plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in transitional UMP coverage during the gap month(s) prior to when the UMP Classic medicare plan begins.

(f) A subscriber enrolled in medicare who defers enrollment while permanently living outside of the United States may enroll in a PEBB health plan by submitting the required forms and proof of enrollment in medicare parts A and B. Evidence of continuous enrollment in a qualified coverage is waived while a subscriber enrolled in medicare lives outside of the United States:

(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 subscriber permanently moved back to the United States. The required forms and proof of enrollment in medicare parts A and B must be received by the PEBB program no later than 60 days after the date of the permanent move or the date the subscriber provides notification of such move, whichever is later. PEBB health plan coverage begins the first day of the month after the permanent move or the date the subscriber provides notification of such move, whichever is later.

Note: Enrollment in the PEBB program's MA plan, MA-PD plan, or the UMP Classic medicare plan may not be retroactive.
(1) If a subscriber elects to enroll in a MA plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in a plan with the same contracted vendor during the gap month(s) prior to when the MA coverage begins.
(2) If a subscriber elects to enroll in a MA-PD plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in transitional coverage as designated by the director or designee during the gap month(s) prior to when the MA-PD coverage begins.
(3) If a subscriber elects to enroll in the UMP Classic medicare plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in transitional UMP coverage during the gap month(s) prior to when the UMP Classic medicare plan begins.

(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)~~)) (f) 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.

(8) If a subscriber elects to enroll a dependent in PEBB health plan coverage as described in subsection (6) or (7) of this section, the dependent must be enrolled in the same PEBB medical and PEBB dental plan as the subscriber.

Exceptions: (1) If a subscriber selects a medicare supplement plan ((or)), a MA-PD plan, or the UMP Classic medicare plan, nonmedicare enrollees will be enrolled in the 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.
(2) If a subscriber selects a medicare supplement plan, MA-PD plan, or any other medicare plan, they may elect a PEBB vision plan available for any nonmedicare enrollees.

(9) A nonmedicare subscriber must enroll in PEBB medical to be able to enroll in PEBB dental, in PEBB vision, or in both PEBB dental and PEBB vision. Any nonmedicare dependents they elect to enroll must be enrolled in the same PEBB medical, PEBB dental, and PEBB vision plan.

(10) 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 MA plan, ((~~then~~)) a MA-PD plan, or the UMP Classic medicare plan, the enrollment will terminate on the last day of the month when the ((~~MA~~)) plan disenrollment form is received.

((~~(10)~~)) (11) When a retiree becomes eligible for the employer contribution toward PEBB or SEBB benefits, PEBB retiree insurance coverage will be automatically deferred. The subscriber will be exempt from the deferral form requirement.

Note: When the subscriber is no longer eligible for the employer contribution toward PEBB or SEBB benefits, they may enroll in PEBB retiree insurance coverage as described in WAC 182-12-171 or continue in a deferred status if they meet the requirements described in WAC 182-12-200 or this section.

AMENDATORY SECTION (Amending WSR 22-13-160, filed 6/21/22, effective 1/1/23)

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 26. 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 180 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 60 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.

Note: Enrollment in the PEBB program's medicare advantage (MA) ((~~or~~)) plan, medicare advantage-prescription drug (MA-PD) plan , or the Uniform Medical Plan (UMP) Classic medicare plan may not be retroactive.
(1) If a subscriber elects to enroll in a MA plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in a plan with the same contracted vendor during the gap month(s) prior to when the MA coverage begins.
(2) If a subscriber elects to enroll in a MA-PD plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in ((~~Uniform Medical Plan (UMP) Classic~~)) transitional coverage as designated by the director or designee during the gap month(s) prior to when the MA-PD coverage begins.
(3) If a subscriber elects to enroll in the UMP Classic medicare plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in transitional UMP coverage during the gap month(s) prior to when the UMP Classic medicare plan begins.

For surviving spouses, state registered domestic partners, and children who enroll, monthly health plan premiums and applicable premium surcharges must be paid by the survivor as described in WAC 182-08-180 (1)(c) except as provided in RCW 41.26.510(5) and 43.43.285 (2)(b).

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

(a) Enroll in a PEBB health plan. Any of the following enrollment applies to survivors who are not enrolled in medicare. The enrollment described in (a)(i) and (ii) of this subsection applies to survivors enrolled in medicare:

(i) Enroll in PEBB medical; ((~~or~~))

(ii) Enroll in PEBB medical and PEBB dental((~~.~~));

(iii) ((~~Dental only is not an option.~~)) Enroll in PEBB medical and PEBB vision; or

(iv) Enroll in PEBB medical, PEBB dental, and PEBB vision.

(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). Survivors who defer enrollment as described in WAC 182-12-205 (3)(a) through (e) 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. Survivors who defer enrollment as described in WAC 182-12-205 (3)(f) must provide proof of enrollment in medicare parts A and B; evidence of continuous enrollment in a qualified coverage is waived if the deferment is based on WAC 182-12-205 (3)(f).

Note: Enrollment in the PEBB program's MA ((~~or~~)) plan, MA-PD plan, or the UMP Classic medicare plan may not be retroactive.
(1) If a subscriber elects to enroll in a MA plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in a plan with the same contracted vendor during the gap month(s) prior to when the MA coverage begins.
(2) If a subscriber elects to enroll in a MA-PD plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in ((~~UMP Classic~~)) transitional coverage as designated by the director or designee during the gap month(s) prior to when the MA-PD coverage begins.
(3) If a subscriber elects to enroll in the UMP Classic medicare plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in transitional UMP coverage during the gap month(s) prior to when the UMP Classic medicare plan begins.

(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,~~)) meet the requirements to defer enrollment as described in subsection (7)(b)((~~(i)~~)) of this section.

WSR 24-18-087
PERMANENT RULES
COLUMBIA BASIN COLLEGE
[Filed August 30, 2024, 9:58 a.m., effective September 30, 2024]

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

Purpose: WAC 132S-400-115 (12)(a)(iv) must reflect the accurate purpose for the community bulletin board for first amendment rights.

Citation of Rules Affected by this Order: Amending WAC 132S-400-115 (12)(a)(iv).

Statutory Authority for Adoption: RCW 28B.50.140.

Adopted under notice filed as WSR 24-15-114 on July 22, 2024.

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

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

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

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

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

Date Adopted: August 30, 2024.

Corey Osborn, Vice President
Human Resources and Legal Affairs

OTS-5651.1

AMENDATORY SECTION (Amending WSR 20-03-046, filed 1/9/20, effective 2/9/20)

WAC 132S-400-115 Use of facilities. (1) Subject to the regulations and requirements of this policy, noncollege groups may use the college's designated public areas, as identified in subsection (12) of this section for first amendment activities between the hours of 7:00 a.m. and 10:00 p.m.

(2) Signs shall be no larger than three feet by five feet and no individual may carry more than one sign.

(3) Any sound amplification device may only be used at a volume which does not disrupt or disturb the normal use of classrooms, offices or laboratories or any previously scheduled college event or activity.

(4) All sites used for first amendment activities should be cleaned up and left in their original condition and may be subject to inspection by a representative of the college after the event. Reasonable charges may be assessed against the sponsoring organization for the costs of extraordinary clean-up or for the repair of damaged property.

(5) All fire, safety, sanitation or special regulations specified for the event are to be obeyed. The college cannot and will not pro-

vide utility connections or hook-ups for purposes of first amendment activities conducted pursuant to this policy.

(6) The event must not be conducted in such a manner to obstruct vehicular, bicycle, pedestrian or other traffic or otherwise interfere with ingress or egress to the college, or to college buildings or facilities, or to college activities or events. The event must not create safety hazards or pose unreasonable safety risks to college students, employees or invitees to the college.

(7) The event must not interfere with educational activities inside or outside any college building or otherwise prevent the college from fulfilling its mission and achieving its primary purpose of providing an education to its students. The event must not materially infringe on the rights and privileges of college students, employees or invitees to the college.

(8) There shall be no overnight camping on college facilities or grounds. Camping is defined to include sleeping, carrying on cooking activities, or storing personal belongings, for personal habitation, or the erection of tents or other shelters or structures used for purposes of personal habitation.

(9) College facilities may not be used for commercial sales, solicitations, advertising or promotional activities, unless:

(a) Such activities serve educational purposes of the college; and

(b) Such activities are under the sponsorship of a college department of office or officially chartered student club.

(10) The event must also be conducted in accordance with any other applicable college policies and regulations, local ordinances and state or federal laws.

(11) College buildings, rooms, and athletic fields may be rented by noncollege groups in accordance with the college's facilities use policy.

(12) The college designates the following area(s) as the designated public areas for use by noncollege groups for first amendment activities on campus:

(a) With respect to the Pasco campus:

(i) Mural gathering area (concrete pad north of the A building);

(ii) A building gathering area (southeast corner near the arbor and seating area);

(iii) Gjerde Center gathering area (northeast concrete portion in front of the main entrance to the H building); and

(iv) Community bulletin board posting printed materials only (located at the west entrance to the Thornton Building).

(b) With respect to the Richland campuses:

(i) Public sidewalks for all campuses;

(ii) Richland Health Science Center located at 891 Northgate Drive, limited to the east or west side of the entrance concrete pad; and

(iii) Richland Original Campus located at 901 Northgate Drive, limited to the walkway space between buildings RB and RC, not to exceed the width of where the building ends immediately adjacent to the walkway.

(13) Noncollege groups that seek to use the designated public fora to engage in first amendment activities shall provide notice to the campus security office no later than ((~~twenty-four~~)) 24 hours prior to the event along with the following information, which shall be used for notification purposes only:

(a) The name, address and telephone number of the individual, group, entity or organization sponsoring the event (hereinafter "the sponsoring organization");

(b) The name, address and telephone number of a contact person for the sponsoring organization;

(c) The date, time and requested location of the event;

(d) The type of sound amplification devices to be used in connection with the event, if any; and

(e) The estimated number of people expected to participate in the event.

(14) Noncollege group events shall not last longer than five hours from beginning to end.

WSR 24-18-088
PERMANENT RULES
HEALTH CARE AUTHORITY

[Filed August 30, 2024, 10:32 a.m., effective September 30, 2024]

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

Purpose: The health care authority has developed this new chapter to establish standards for issuing endorsements to mobile rapid response crisis teams and community-based crisis teams, as required by RCW 71.24.903.

Citation of Rules Affected by this Order: New WAC 182-140-0010, 182-140-0020, 182-140-0030, 182-140-0040, 182-140-0050, 182-140-0060, 182-140-0070, 182-140-0080, 182-140-0090, 182-140-0100, 182-140-0110, 182-140-0120, and 182-140-0130.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Other Authority: RCW 71.24.903.

Adopted under notice filed as WSR 24-14-145 on July 3, 2024.

Changes Other than Editing from Proposed to Adopted Version:

Proposed/Adopted	WAC Subsection	Reason
WAC 182-140-0020		
Proposed	**"Mental health professional (MHP)** "means the same as in WAC 182-538D-0200.	Revised to reference the statute that has current MHP definition.
Adopted	**"Mental health professional (MHP)** "means the same as in RCW 71.05.020.	
WAC 182-140-0080 (1)(e)		
Proposed	(1) **Staffing plan.** An eligible organization must have a staffing plan that includes: (e) Policies and procedures for ensuring follow-up crisis services occur after an initial response.	Revised based on stakeholder input that follow up crisis services may not be necessary in some circumstances.
Adopted	(1) **Staffing plan.** An eligible organization must have a staffing plan that includes: (e) Policies and procedures for ensuring follow-up crisis services occur after an initial response, as clinically appropriate.	
WAC 182-140-0080 (3)(a)		
Proposed	(3) **Mobile rapid response crisis teams and nonexempt CBCTs.** Eligible organizations that are not seeking the personnel exemption in RCW 71.24.903(3) must have sufficient staffing to ensure an in-person response is available 24 hours a day, seven days a week, and must: (a) Meet the required response times described in RCW 71.24.903;	Revised to correct the reference to response times based on stakeholder comments. The response times in the BH-ASO contract apply to this section.
Adopted	(3) **Mobile rapid response crisis teams and nonexempt CBCTs.** Eligible organizations that are not seeking the personnel exemption in RCW 71.24.903(3) must have sufficient staffing to ensure an in-person response is available 24 hours a day, seven days a week, and must: (a) Meet the required response times identified in the BH-ASO contract;	
WAC 182-140-0090 (3)(a)		

Proposed/Adopted	WAC Subsection	Reason
Proposed	(3) **Training required within 180 days.** All staff must complete the following training within 180 calendar days of their hiring date: (a) Authority-sponsored certified crisis intervention specialist training;	Revised, based on stakeholder comments, to clarify that trainers need to be approved by the agency. Trainers are not required to be sponsored by the agency.
Adopted	(3) **Training required within 180 days.** All staff must complete the following training within 180 calendar days of their hiring date: (a) Authority-approved certified crisis intervention specialist training;	
WAC 182-140-0090(5)		
Proposed	(5) **Crisis supervision training for supervisors.** Supervisors must complete authority-sponsored crisis supervision training that includes the following:	Revised to align with the change made to WAC 182-140-0090 (3)(a).
Adopted	(5) **Crisis supervision training for supervisors.** Supervisors must complete authority-approved crisis supervision training that includes the following:	

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 13, Amended 0, Repealed 0.

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

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

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 13, Amended 0, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 13, Amended 0, Repealed 0.

Date Adopted: August 30, 2024.

Wendy Barcus
Rules Coordinator

OTS-5476.6

Chapter 182-140 WAC
MOBILE RAPID RESPONSE CRISIS TEAM ENDORSEMENT STANDARDS

NEW SECTION

WAC 182-140-0010 General. (1) This chapter establishes standards for issuing endorsements to mobile rapid response crisis teams (MRRCTs) and community-based crisis teams (CBCTs) according to RCW 71.24.903 and the authority's best practice guide. MRRCTs and CBCTs provide on-site interventions for people experiencing behavioral health emergencies.

(2) Eligible MRRCTs and CBCTs may receive an endorsement from the authority that allows a team under contract with a behavioral health administrative services organization to receive enhanced rates and supplemental performance payments.

(3) Tribal governments may seek an endorsement using the attestation process described in WAC 182-140-0060.

NEW SECTION

WAC 182-140-0020 Definitions. The following definitions apply to this chapter:

"Authority" means the Washington state health care authority.

"Behavioral health administrative services organization (BH-ASO)" means the same as in WAC 182-538-050.

"Behavioral health emergency" means a person is experiencing a significant behavioral health crisis that requires an immediate in-person response due to level of risk or lack of means for safety planning.

"Calendar days" means all days, including Saturdays, Sundays, and designated holidays under WAC 357-31-005.

"Community-based crisis team (CBCT)" means a team that is part of an emergency medical services agency, a fire service agency, a public health agency, a medical facility, a nonprofit crisis response provider, or a city or county government entity, other than a law enforcement agency, that provides the on-site, community-based interventions of a mobile rapid response crisis team (MRRCT) for people who are experiencing behavioral health emergencies.

"Eligible organization" means an entity serving as a mobile rapid response crisis team (MRRCT) or a community-based crisis team (CBCT) that is seeking an endorsement. An eligible organization must be one of the following:

- Any entity below operated by a tribal government;
- City or county government entity, other than a law enforcement agency;
- Emergency medical service agency;
- Fire department;
- Fire service agency;
- Licensed or certified behavioral health agency;
- Medical facility;
- Nonprofit crisis response provider;
- Nonprofit organization;
- Public health agency.

"Endorsed team" means a mobile rapid response crisis team (MRRCT) or a community-based crisis team (CBCT) that meets the endorsements standards in this chapter.

"Endorsement" or **"certificate of endorsement"** means a voluntary credential issued by the authority to a mobile rapid response crisis team (MRRCT) or a community-based crisis team (CBCT), which allows the team to become eligible for supplemental performance payments.

"Enhanced rate" means the increased rate paid to endorsed mobile rapid response crisis teams (MRRCT) and community-based crisis teams (CBCT) as described in RCW 71.24.903.

"Exempt community-based crisis team" means a team comprised solely of an emergency medical services agency, whether part of a fire service agency or a private entity, located in a rural county in east-

ern Washington with a population of less than 60,000 residents. Under RCW 71.24.903, minimum personnel standards do not apply in exempt eastern Washington counties.

"Exempt eastern Washington counties" means the following counties: Adams, Asotin, Columbia, Douglas, Ferry, Garfield, Kittitas, Klickitat, Lincoln, Okanogan, Pend Oreille, Skamania, Stevens, and Whitman.

"Mental health care provider (MHCP)" means a provider recognized by the department of health as a registered, agency affiliated counselor who has primary responsibility for implementing an individualized plan for mental health rehabilitation services.

"Mental health professional (MHP)" means the same as in RCW 71.05.020.

"Mobile rapid response crisis team (MRRCT)" means a team that provides professional, on-site, community-based interventions such as outreach, de-escalation, stabilization, resource connection, and follow-up support for people who are experiencing a behavioral health emergency. A MRRCT must:

• Include certified peer counselors as a best practice to the extent practical based on workforce availability; and

• Meet standards for response times established by the authority's contracted BH-ASO.

"Regional dispatch protocols" means the protocols adopted by the regional BH-ASO to establish guidelines for dispatching necessary crisis services.

"Rural area" means a zip code with a population of less than 500 residents per square mile, an Indian reservation, and any location that requires travel by ferry or international travel to reach.

"Suburban area" means a zip code with a population of more than 500 residents per square mile but less than 3,000 residents per square mile.

"Supplemental performance payment" means an optional, additional payment described in RCW 71.24.903(10) that is greater than the enhanced rate. Endorsed teams are eligible for the supplemental performance payment if they demonstrate that they meet the required standards in this chapter.

"Urban area" means a zip code with a population of more than 3,000 residents per square mile.

NEW SECTION

WAC 182-140-0030 Application process. (1) **Application.** To apply for an endorsement, an eligible organization must submit an application for endorsement to the authority and all documentation required in subsection (3) of this section. Eligible organizations may apply:

(a) Online through the authority's website; or

(b) By completing the Crisis Team Endorsement Application form (HCA 82-0588) and mailing it to the authority.

(2) **Submission periods for applications.**

(a) A team must submit its completed application by January 1st to be eligible for a contract effective in July of the same year.

(b) A team must submit its completed application by July 1st to be eligible for a contract effective in January of the following year.

(c) The authority defers submissions received after the deadlines in (a) and (b) of this subsection until the next contract cycle.

(3) **Required documentation.** An eligible organization applying for an endorsement must also submit:

(a) A current contract with the behavioral health administrative services organization (BH-ASO) serving the region where the eligible organization will operate or a letter of intent to contract once the team is endorsed;

(b) The eligible organization's policies and procedures that outline how it will comply or how it currently complies with the training requirements in WAC 182-140-0090;

(c) A copy of the transportation plan outlined in WAC 182-140-0100; and

(d) A copy of the eligible organization's staffing plan described in WAC 182-140-0080.

(4) **Community-based crisis teams (CBCT).** A CBCT that intends to contract with a licensed and certified behavioral health agency (BHA) to provide staff must also submit:

(a) The contracting BHA's active contract with the BH-ASO located in the region where the CBCT will operate; or

(b) A letter of intent from the BH-ASO to establish a contractual relationship with the contracting BHA upon the CBCT receiving an endorsement.

NEW SECTION

WAC 182-140-0040 Application requirements for exempt community-based crisis teams. A community-based crisis team (CBCT) exempt from minimum personnel standards must submit the application described in WAC 182-140-0030(1) and:

(1) Policies and procedures that outline how the exempt CBCT will comply with the training requirements in WAC 182-140-0090;

(2) A memorandum of understanding with a licensed behavioral health agency (BHA) certified to provide crisis services and direct, real-time consultation through a behavioral health provider while the team is responding to a crisis call;

(3) A copy of the BHA's active contract with the behavioral health administrative services organization (BH-ASO) located in the region where the exempt CBCT will operate;

(4) A written plan describing how the responders will access the required real-time consultation with the behavioral health clinicians, which includes:

(a) The equipment to be used; and

(b) How the consultation will be documented and by which party.

(5) A staffing plan that identifies:

(a) How the exempt CBCT will be staffed 24 hours per day, seven days a week, with an outline of when each position is available to respond; and

(b) Policies and procedures that describe how staff will respond safely and meet the time requirements in the regional dispatch protocols.

(6) Policies and procedures to ensure follow-up crisis services are provided after an initial response or a copy of a memorandum of understanding with a mobile rapid response crisis team (MRRCT) to provide follow-up crisis services. The memorandum of understanding must:

(a) Be with an MRRCT that is licensed and certified to provide crisis services that are clinically appropriate; and

(b) Contain clear guidelines on how and when the transfer of care will occur and the expectation to follow up within a defined set of time.

NEW SECTION

WAC 182-140-0050 Endorsement renewal. Endorsed teams seeking renewal must submit the application and all current documentation described in WAC 182-140-0030.

(1) An endorsed team must submit its renewal application and current documentation every three years. For a contract cycle from:

(a) January 1st through June 30th, the endorsed team's submission is due by July 1st of the previous year.

(b) July 1st through December 31st, the endorsed team's submission is due by January 1st of the current year.

(2) Failure to timely complete this requirement may result in suspension or revocation of the team's endorsement and denial of any enhanced rates or supplemental payments.

NEW SECTION

WAC 182-140-0060 Tribal endorsement process. (1) Tribal eligible organizations may seek endorsement through the government-to-government process described in this section.

(2) Under this process, a tribal eligible organization must submit:

(a) The endorsement application and materials described in WAC 182-140-0030, as applicable;

(b) A Tribal Endorsement Attestation form (HCA 82-0599), confirming the organization meets the state minimum standards for mobile crisis services as described in WAC 182-140-0080, 182-140-0090, and 182-140-0100;

(c) A copy of its policies and procedures for the endorsement standards identified in (b) of this subsection; and

(d) Photographs showing that the organization's vehicle or vehicles meet the requirements of WAC 182-140-0100 (2), (3), and (4).

(3) After all materials are submitted, the authority and the tribal eligible organization meet to review and finalize all application materials and discuss any technical assistance needed.

(4) Following review and acceptance of the application and related materials, the authority issues the tribal eligible organization a certificate of endorsement and:

(a) Notifies all behavioral health administrative services organizations; and

(b) Negotiates an Indian Nation Agreement (INA) with the tribe that outlines:

(i) Government-to-government monitoring; and

(ii) Denial, suspension, and revocation procedures under the terms of the parties' negotiated INA.

(5) The provisions of WAC 182-140-0120 and 182-140-0130 do not apply to tribal eligible organizations.

NEW SECTION

WAC 182-140-0070 On-site review process. Eligible organizations must successfully complete and pass an on-site review.

(1) **On-site review.** The authority schedules the on-site review after it receives and approves all documentation required for an endorsement as described in this chapter. The on-site review examines the following:

(a) Employee files;

(b) Training materials and trainer qualifications;

(c) Any vehicle operated by an eligible organization; and

(d) Records of training certificates, if required, and driver licenses for all personnel who operate the vehicle.

(2) **Completion of on-site review.** After completing its on-site review, the authority sends the eligible organization a notice for any items that do not meet endorsement standards.

(a) The eligible organization has 30 calendar days from the date of the notice to resolve any items that do not meet endorsement standards.

(b) If the eligible organization has not resolved all outstanding issues within 30 days, the authority may deny the application.

(3) **Issuance of endorsement.** The authority issues a certificate of endorsement after it has reviewed and approved all required documentation and the eligible organization has satisfactorily completed its on-site review. Once endorsed, the eligible organization receives the enhanced rate.

(4) **Tribal exemption.** Tribal eligible organizations seeking endorsement through the process described in WAC 182-140-0060 are exempt from the on-site review.

NEW SECTION

WAC 182-140-0080 Staffing standards. To be endorsed, eligible organizations must meet the staffing standards described in this section.

(1) **Staffing plan.** An eligible organization must have a staffing plan that includes:

(a) How an eligible organization will be staffed 24 hours a day, seven days a week, including when each position is available to respond and where the teams are located;

(b) How peers will be incorporated into the response team;

(c) How peers will be recruited and any anticipated challenges for them;

(d) Policies and procedures for how staff will respond safely and meet the time requirements in the regional dispatch protocols; and

(e) Policies and procedures for ensuring follow-up crisis services occur after an initial response, as clinically appropriate.

(2) **Additional staffing documentation for community-based crisis teams (CBCT).** A CBCT that contracts with a licensed and certified behavioral health agency to meet the staffing requirements described in WAC 182-140-0090 must have a staffing plan that includes:

(a) Which staff are involved in the agreement;

(b) The role of each staff member;

(c) How staff will access clinical supervision 24 hours a day, seven days a week, for real-time consultation; and

(d) How frequently clinical supervisors will provide ongoing coaching, case consultation, and clinical debriefing in a trauma informed manner, including how to:

(i) Review charts; and

(ii) Provide clinical quality assurance.

(3) **Mobile rapid response crisis teams and nonexempt CBCTs.** Eligible organizations that are not seeking the personnel exemption in RCW 71.24.903(3) must have sufficient staffing to ensure an in-person response is available 24 hours a day, seven days a week, and must:

(a) Meet the required response times identified in the BH-ASO contract;

(b) Provide all outreach in pairs unless it is not clinically appropriate;

(c) Provide follow-up services as clinically appropriate to a person seeking behavioral health assistance and connect the person to ongoing support; and

(d) Be composed of the following behavioral health clinical staff who are appropriately credentialed or licensed within their scope of practice and meet the criteria below:

(i) A mental health professional (MHP);

(ii) A mental health care provider (MHCP);

(iii) A certified peer counselor who meets the criteria in WAC 182-115-0100; or

(iv) Another behavioral health or medical professional working within their scope of practice under an approved staffing plan, as needed, to meet staffing requirements; and

(v) Include at least one MHP or MCHP during an initial response and a certified peer counselor, when available.

(e) Have an MHP supervise when the responding team staff are in the field; and

(f) Have access to an MHP 24 hours a day, seven days a week, for consultation. The consulting MHP may be the team supervisor or another MHP.

NEW SECTION

WAC 182-140-0090 Training standards. An eligible organization's policies and procedures must meet the training standards in this section to receive endorsement. In addition, all staff must receive training sponsored by the authority, behavioral health administrative services organizations, tribes, or eligible organizations, as applicable.

(1) **Required staff training.** All staff must receive the training described in this section, as applicable, before an eligible organization submits its application. Staff hired during or after the application process must complete the training described in this section, following the time requirements in subsections (2) and (3) of this section.

(2) **Training required within 90 days.** All staff must receive the following training within 90 calendar days of their hiring date:

(a) Developmentally appropriate modules for:

(i) Trauma-informed care;

(ii) Harm reduction; and

(iii) Basic de-escalation training.

(b) CPR;

(c) First aid;

(d) Naloxone administration;

(e) Suicide prevention training for health professionals approved by the department of health. Training required for behavioral health clinical staff licensure meets this standard if it is kept up to date; and

(f) Confidentiality standards established in chapters 70.02, 71.34, and 71.05 RCW.

(3) **Training required within 180 days.** All staff must complete the following training within 180 calendar days of their hiring date:

(a) Authority-approved certified crisis intervention specialist training;

(b) Regional crisis system training approved by the behavioral health administrative services organization (BH-ASO), as available; and

(c) Authority-approved training on the Indian health care delivery system, including the government-to-government relationship between the state of Washington and federally recognized Indian tribes.

(4) **Exception for tribes.** The authority considers the staff of teams operated by or for a tribe to meet the applicable requirements in subsection (3)(b) and (c) of this section.

(5) **Crisis supervision training for supervisors.** Supervisors must complete authority-approved crisis supervision training that includes the following:

(a) Trauma-informed supervision; and

(b) Monitoring for staff burnout.

(6) **Vehicle operation training.** Before operating an eligible organization's vehicle, staff must be trained in the following:

(a) Defensive driving;

(b) Operation of equipment compliant with the Americans with Disabilities Act; and

(c) Any specialized training necessary to operate the vehicle.

(7) **Additional training.** Eligible organizations must also provide any additional training required by the authority.

(8) **Approval of existing training materials.** An eligible organization may apply to have its training materials approved to meet the criteria required in this section. The organization must submit its training materials to the authority for approval as part of the application process described in WAC 182-140-0030.

(9) **Approved trainers.** Trainers must be approved by the authority. An organization may apply to have its own staff become approved trainers when:

(a) The staff member has completed the initial trainer course for specified trainings; and

(b) The organization has reviewed the staff member's credentials to ensure the person is competent to train others about the subject matter.

NEW SECTION

WAC 182-140-0100 Transportation, equipment, and communication standards. An eligible organization must meet the transportation, vehicle, and communication standards in this section to receive an endorsement.

(1) **Transportation plan.** An eligible organization must have a transportation plan.

(a) The plan's policies and procedures must explain how the organization will:

(i) Comply with regional transportation procedures;

(ii) Provide timely transportation when a transport need is identified, as clinically appropriate;

(iii) Ensure safe transport for passengers and staff;

(iv) Ensure all staff who transport passengers are legally qualified to operate the vehicle;

(v) Arrange for alternative transport when the team is unable to provide transportation;

(vi) Ensure that people experiencing mobility disabilities have safe transport to a facility; and

(vii) Document the reasons for an unsuccessful transport and how to address them in the future.

(b) An eligible organization must follow incident reporting guidelines and notify the authority of any critical incidents or accidents that occur during transport. Eligible organizations must use the critical incident reporting system.

(2) **Vehicle requirements.** An eligible organization must have access to an adequate number of vehicles to respond to and transport people experiencing significant behavioral health emergencies to a location that will provide the appropriate level of crisis stabilization services.

(a) Vehicles must:

(i) Be owned or leased by the eligible organization;

(ii) Have proper licensing and registration;

(iii) Be maintained in good working order; and

(iv) Meet all safety requirements.

An automotive service excellence (ASE) certified mechanic must complete a certificate of safety to demonstrate that the vehicle has passed a uniform vehicle safety inspection before the authority issues an endorsement or renewal. If there is concern that a vehicle does not meet all safety requirements after receiving an ASE certification, the authority or the behavioral health administrative services organization (BH-ASO) may require another formal inspection by a qualified professional.

(v) Have vehicle insurance coverage that applies to private, nonprofit transportation providers and meets the minimum limits of WAC 480-31-070;

(vi) Have 24 hour, seven days a week access to vehicles that meet the Americans with Disabilities Act (ADA) requirements for transporting a person experiencing mobility disabilities or be a licensed ambulance or aid vehicle as described in chapter 18.73 RCW.

(b) If an eligible team does not have a vehicle that meets the requirements of (a)(vi) of this subsection, the team must have policies and procedures on how it will transport someone experiencing mobility disabilities.

(3) **Equipment.** All equipment must be maintained in good working order and requires a formal inspection by a qualified professional when requested by the authority or the contracted behavioral health administrative services organization (BH-ASO).

(a) **Vehicle equipment.** Vehicles operated by eligible organizations must have:

(i) The appropriate equipment to ensure the person being transported is unable to interfere with the driver's safe operation of the vehicle;

(ii) Doors and windows that can be secured by the driver;

(iii) Appropriate seat belts for the safety of staff and the person being transported, including child safety seats or booster seats as necessary;

(iv) Appropriate or necessary equipment to respond to weather conditions and roadside emergencies; and

(v) The ability to track the location of the vehicle and team.

(b) **Communication equipment.** All vehicles must be equipped with communication equipment that is in good working order.

(i) Equipment must allow for:

(A) Direct two-way communication between the team and its dispatch control point; and

(B) Communication with emergency services.

(ii) All teams must be equipped to access electronic health records (EHR) and referral records through a remote means, where coverage is available, and be able to print records when needed; and

(iii) All equipment must be compatible with authority-designated technology platforms.

(4) **Other equipment.** Eligible organizations must carry Naloxone.

NEW SECTION

WAC 182-140-0110 Endorsed team supplemental performance payment. (1) Only endorsed teams that respond to behavioral health emergencies and meet the response times described in RCW 71.24.903 for rural, suburban, and urban areas are eligible to receive a supplemental performance payment.

(2) Teams must follow behavioral health administrative services organization (BH-ASO) data reporting requirements to document their response times.

(3) The authority calculates response times based on the reported information on a quarterly basis.

(4) The authority certifies a team that has met performance requirements and directs the BH-ASO to issue the performance payment.

NEW SECTION

WAC 182-140-0120 Notice of noncompliance. (1) **Denial of application.** The authority sends a notice of noncompliance that may result in the denial of an eligible organization's initial application or the denial of an endorsed team's renewal application if the eligible organization or endorsed team:

(a) Fails to meet the applicable endorsement standards described in WAC 182-140-0080, 182-140-0090, and 182-140-0100;

(b) Fails to cooperate or disrupts the authority's representatives during an on-site review or during a behavioral health administrative services organization's (BH-ASO) complaint investigation under its contract with the endorsed team;

(c) Knowingly, or with reason to know, makes a false statement of fact or fails to submit required information;

(d) Holds itself out as endorsed when the authority has denied or revoked the organization's endorsement, or the organization has surrendered its endorsement;

(e) Fails to timely provide satisfactory application materials;

(f) Fails to comply with any other requirement for endorsement described in this chapter; or

(g) Fails to meet the terms of its contract with the BH-ASO.

(2) **Endorsement suspension.** The authority sends an endorsed team a notice of noncompliance that may result in an endorsement suspension if the endorsed team fails to:

(a) Submit renewal materials prior to the closing of the application period;

(b) Schedule or timely complete the on-site review;

(c) Meet the endorsement standards outlined in WAC 182-140-0080, 182-140-0090, and 182-140-0100;

(d) Provide the services for which the eligible organization is endorsed; or

(e) Follow the terms of their BH-ASO contract.

(3) **Exception for tribal organizations.** Subsections (1) and (2) of this section and WAC 182-140-0130 do not apply to tribal eligible organizations or tribal endorsed organizations. Tribal organizations follow the process laid out in the organization's Indian Nation Agreement described in WAC 182-140-0060 regarding any noncompliance with the endorsement standards in this chapter.

NEW SECTION

WAC 182-140-0130 Correction of noncompliance. If an eligible organization or endorsed team receives a notice of noncompliance, the organization or team may demonstrate compliance as follows:

(1) **Correction of application.** For notices of noncompliance for an eligible organization's application:

(a) An eligible organization has 30 calendar days from the date of the notice of noncompliance to submit proof of all corrected deficiencies.

(b) The authority reviews the supplemental information and responds to the eligible organization within 30 calendar days of receipt.

(c) If the organization or team fails to timely submit proof of the corrected deficiency, the authority denies the application.

(2) **Correction of endorsement standards.** An endorsed team has 30 calendar days from the date of the notice of noncompliance to submit proof of all corrected deficiencies.

(a) An endorsed team must submit:

(i) Documentation proving compliance with standards; or

(ii) A plan to be approved by the authority to correct noncompliant compliance procedures within 90 calendar days of the notice of noncompliance, or both.

(b) The endorsed team must provide the authority with evidence of the correction within 90 calendar days of the notice of noncompliance.

(c) The authority reviews the evidence of the correction and, within 30 calendar days of receipt, determines whether the team is compliant.

(d) If the authority's evaluation confirms the endorsed team has satisfied the requirements for compliance, the authority provides written notice confirming the team's compliance.

(e) If an endorsed team fails to satisfy the requirements for compliance within the 30-day period, the authority issues a 90-calendar-day suspension notice. A suspended team is not eligible for supplemental performance payments during its suspension, and the suspension may impact the team's priority response status within the regional dispatch protocols.

(f) If an endorsed team fails to satisfy the requirements for compliance within the suspension period, the authority issues a notice of revocation of endorsement.

(3) **Endorsement revocation.** The authority sends an eligible organization a notice of noncompliance that may result in an endorsement revocation if the eligible organization fails to:

(a) Timely renew its endorsement every three years; or

(b) Remedy the cause of a suspended endorsement.

(4) **Surrender of endorsement.** An endorsed team may surrender its endorsement at any time. A team that surrenders its endorsement may continue to operate, but is no longer eligible to receive enhanced payments or supplemental performance payments.

WSR 24-18-101
PERMANENT RULES
DEPARTMENT OF
LABOR AND INDUSTRIES

[Filed September 3, 2024, 11:52 a.m., effective October 7, 2024]

Effective Date of Rule: October 7, 2024.

Purpose: In May 2023, the division of occupational safety and health (DOSH) received notification from the Federal Occupational Safety and Health Administration (OSHA) relating to DOSH's fall protection standard. The notification advised the department of labor and industries (L&I) of needed amendments to the fall protection rule in chapter 296-880 WAC in order to be at-least-as-effective-as those administered by OSHA. This rule making makes changes to sections of the current fall protection rule that address leading edge work, safety monitor system requirements, and roofing activity on low pitched roofs to make them at-least-as-effective-as OSHA, as required by the Washington state plan.

The adopted rule establishes the following safety standards:

- Under the fall restraint system definition removed "/prevent," added "or" to clarify personal fall restraint systems and removed "warning line systems, or a warning line system and safety monitor."
- Under safety monitoring system definition removed "restraint," "including the leading edge" and "or other walking working surface."
- Added exemption stating "A safety monitoring system may be used when engaged in roofing work on a low pitched roof" for further clarification as to when this system is appropriate.
- Removed language in WAC 296-880-40044 that is no longer allowable under WAC 296-880-40045.
- Removed "or leading edge work on low pitched surfaces" in WAC 296-800-40045 as it is no longer allowable.

Citation of Rules Affected by this Order: WAC 296-880-095, 296-880-30005, 296-880-40040, and 296-880-40045.

Statutory Authority for Adoption: RCW 49.17.010, 49.17.040, 49.17.050, and 49.17.060.

Other Authority: Chapter 19.17 RCW.

Adopted under notice filed as WSR 24-14-112 on July 2, 2024.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 4, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

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

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

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

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

Date Adopted: September 3, 2024.

Joel Sacks
Director

OTS-4979.1

AMENDATORY SECTION (Amending WSR 22-19-082, filed 9/20/22, effective 11/1/22)

WAC 296-880-095 Definitions. For the purposes of this chapter the following definitions apply:

(1) **Aerial device.** A vehicle-mounted device, telescoping or articulating, or both, which is used to position personnel.

(2) **Affected area.** The distance away from the edge of an excavation equal to the depth of the excavation up to a maximum distance of 15 feet. For example, an excavation 10 feet deep has an affected area extending 10 feet from the edge of any side of the excavation.

(3) **Anchorage.** A secure point of attachment for lifelines, lanyards, or deceleration devices which is capable of withstanding the forces specified in this chapter.

(4) **Boom-supported elevating work platform.** A self-propelled, integral chassis, elevating work platform with a boom-supported platform that can be positioned completely beyond the base.

(5) **Catch platform.** A type of fall arrest system that consists of a platform installed within four vertical feet of the fall hazard, is at least 45 inches wide and is equipped with a standard guardrail system on all exposed sides.

(6) **Catenary line.** See "horizontal lifeline."

(7) **Competent person.** An individual knowledgeable of fall protection equipment, including the manufacturer's recommendations and instructions for the proper use, inspection, and maintenance; and who is capable of identifying existing and potential fall hazards; and who has the authority to take prompt corrective action to eliminate those hazards; and who is knowledgeable of the requirements contained in this chapter regarding the installation, use, inspection, and maintenance of fall protection equipment and systems.

(8) **Connector.** A device which is used to connect parts of the personal fall arrest system and positioning device systems together. It may be an independent component of the system, such as a carabiner, or it may be an integral component of part of the system (such as a buckle or D-ring sewn into a harness, or a snap hook spliced or sewn to a lanyard or self-retracting lanyard).

(9) **Construction work.** All or any part of excavation, construction, erection, alteration, repair, demolition, and dismantling of buildings and other structures and all operations in connection therewith; the excavation, construction, alteration and repair of sewers, trenches, caissons, conduits, pipe lines, roads and all operations pertaining thereto; the moving of buildings and other structures, and to the construction, alteration, repair, or removal of wharfs, docks, bridges, culverts, trestles, piers, abutments or any other construction, alteration, repair or removal work related thereto.

(10) **Deceleration device.** Any mechanism, such as a rope grab, ripstitch lanyard, specifically woven lanyard, tearing or deforming lanyards, automatic self-retracting lifelines/lanyards, etc., which serves to dissipate a substantial amount of energy during a fall arrest, or otherwise limit the energy imposed on an employee during fall arrest.

(11) **Deceleration distance.** The additional vertical distance a falling employee travels, excluding lifeline elongation and free fall distance, before stopping, from the point at which the deceleration

device begins to operate. It is measured as the distance between the location of an employee's full body harness attachment point at the moment of activation (at the onset of fall arrest forces) of the deceleration device during a fall, and the location of that attachment point after the employee comes to a full stop.

(12) **Dropline.** A vertical lifeline secured to an upper anchorage for the purpose of attaching a lanyard or device.

(13) **Elevating work platform.** A device used to position personnel, along with their necessary tools and materials, at work locations. It includes a platform and an elevating assembly. It may be vehicle-mounted or have an integral chassis for mobility and as a means of support.

(14) **Equivalent.** Alternative designs, materials, or methods to protect against a hazard which the employer can demonstrate and will provide an equal or greater degree of safety for employees than the methods, materials, or designs specified in this standard.

(15) **Fall arrest system.** A fall protection system that will arrest a fall from elevation. Fall arrest systems include personal fall arrest systems that are worn by the user, catch platforms, and safety nets.

(16) **Fall distance.** The actual distance from the worker's support to the level where a fall would stop.

(17) **Fall protection work plan.** A written planning document in which the employer identifies all areas on the job site where a fall hazard of 10 feet or more exists. The plan describes the method or methods of fall protection to be used to protect employees, and includes the procedures governing the installation, use, inspection, and removal of the fall protection method or methods which are selected by the employer. See WAC 296-880-10020.

(18) **Fall restraint system.** A system in which all necessary components function together to restrain((~~/prevent~~)) an employee from falling to a lower level. Types of fall restraint systems include standard guardrail systems((~~,~~)) or personal fall restraint systems((~~, warning line systems, or a warning line system and safety monitor~~)).

(19) **Feasible.** It is possible to perform the work using a conventional fall protection system (i.e., guardrail system, safety net system, or personal fall arrest system) or that it is technologically possible to use any one of these systems to provide fall protection.

(20) **Free fall.** The act of falling before a personal fall arrest system begins to apply force to arrest the fall.

(21) **Free fall distance.** The vertical displacement of the fall arrest attachment point on the employee's full body harness between onset of the fall and just before the system begins to apply force to arrest the fall. This distance excludes deceleration distance, and lifeline/lanyard elongation, but includes any deceleration device slide distance or self-retracting lifeline/lanyard extension before they operate and fall arrest forces occur.

(22) **Full body harness.** A configuration of connected straps that meets the requirements specified in ANSI Z359.1, that may be adjustable to distribute a fall arresting force over at least the thighs, shoulders and pelvis, with provisions for attaching a lanyard, lifeline, or deceleration devices.

(23) **Full body harness system.** A full body harness and lanyard which is either attached to an anchorage meeting the requirements of this chapter; or it is attached to a horizontal or vertical lifeline which is properly secured to an anchorage(s) capable of withstanding the forces specified in this chapter.

(24) **Handrail.** A rail used to provide employees with a handhold for support.

(25) **Hardware.** Snap hooks, D-rings, bucklers, carabiners, adjusters, or O-rings, that are used to attach the components of a fall protection system together.

(26) **Hazardous slope.** A slope from which construction work is performed where normal footing cannot be maintained without the use of devices due to the pitch of the surface, weather conditions, or surface material.

(27) **Hole.** A gap or void two inches or more in its least dimension, in a floor, roof, or other surface.

(28) **Horizontal lifeline.** A rail, rope, wire, or synthetic cable that is installed in a horizontal plane between two anchorages and used for attachment of a worker's lanyard or lifeline device while moving horizontally; used to control dangerous pendulum like swing falls.

(29) **Infrequent.** The task or job is performed only on occasion, when needed (e.g., equipment breakdown), on an occasional basis, or at sporadic or irregular intervals.

(30) **Lanyard.** A flexible line of webbing, rope, or cable used to secure a positioning harness or full body harness to a lifeline or an anchorage point usually two, four, or six feet long.

(31) **Leading edge.** The advancing edge of a floor, roof, or formwork which changes location as additional floor, roof, or formwork sections are placed, formed, or constructed. A leading edge is considered to be an "unprotected side or edge" during periods when it is not actively and continuously under construction.

(32) **Lifeline.** A vertical line from a fixed anchorage or between two horizontal anchorages, independent of walking or working surfaces, to which a lanyard or device is secured. Lifeline as referred to in this text is one which is part of a fall protection system used as back-up safety for an elevated worker or as a restraint for workers on a flat or sloped surface.

(33) **Locking snap hook.** A connecting snap hook that requires two separate forces to open the gate; one to deactivate the gatekeeper and a second to depress and open the gate which automatically closes when released; used to minimize roll out or accidental disengagement.

(34) **Low pitched roof.** A roof having a slope equal to or less than four in 12.

(35) **Maintenance.** The work of keeping a building, machine, roadway, etc., in a state of good repair.

(36) **Manually propelled elevating work platform.** A manually propelled, integral chassis, elevating work platform with a platform that cannot be positioned completely beyond the base.

(37) **Mechanical equipment.** All motor or human propelled wheeled equipment except for wheelbarrows, mopcarts, robotic thermoplastic welders, and robotic crimpers.

(38) **Opening.** A gap or void 30 inches (76 cm) or more high and 18 inches (48 cm) or more wide, in a wall or partition, through which employees can fall to a lower level.

(39) **Personal fall arrest system.** A fall arrest system that is worn by the employee to arrest the employee in a fall from elevation. It consists of an anchor point, connectors, a full body harness, and may include a lanyard, deceleration device, lifeline, or suitable combinations of these.

(40) **Personal fall restraint system.** A fall restraint system that is worn by the employee to keep the employee from reaching a fall

point, such as the edge of a roof or elevated work surface. It consists of an anchor point, hardware assemblies, a full body harness and may include a lanyard, restraint lines, or suitable combinations of these.

(41) **Platform.** A work surface elevated above the surrounding floor or ground.

(42) **Positioning device system.** A full body harness or positioning harness that is worn by an employee, and is rigged to allow an employee to be supported on an elevated vertical or inclined surface, such as a wall, pole or column and work with both hands free from the body support.

(43) **Positioning harness.** A body support that meets the requirements specified in ANSI Z359.1 that encircles and closes around the waist and legs with attachment elements appropriate for positioning work.

(44) **Qualified person.** One who, by possession of a recognized degree, certificate, or professional standing, or who by extensive knowledge, training, and experience, has successfully demonstrated his/her ability to solve or resolve problems related to the subject matter, the work, or the project.

(45) **Repair.** To restore a building, machine, roadway, etc., to an original state after damage or decay.

(46) **Restraint line.** A line from a fixed anchorage or between two anchorages to which an employee is secured in such a way as to prevent the worker from falling to a lower level.

(47) **Roof.** The exterior surface on the top of a building. This does not include floors or formwork which, because a building has not been completed, temporarily become the top surface of a building.

(48) **Roofing work.** The hoisting, storage, application, and removal of roofing materials and equipment, including related insulation, sheet metal, and vapor barrier work, but not including the construction of the roof deck.

(49) **Rope grab.** A fall arrester that is designed to move up or down a lifeline suspended from a fixed overhead or horizontal anchorage point, or lifeline, to which the full body harness is attached. In the event of a fall, the rope grab locks onto the lifeline rope through compression to arrest the fall. The use of a rope grab device is restricted for all restraint applications. See WAC 296-880-40025.

(50) **Runway.** A passageway for persons, elevated above the surrounding floor or ground level, such as a footwalk along shafting or a walkway between buildings.

(51) **Safety line.** See "lifeline."

(52) **Safety monitoring system.** A type of fall ((~~restraint~~)) protection system ((~~in~~)) allowed for use when roofing on a low pitched roof which consists of a warning line and a competent person whose only job responsibility is to recognize and warn employees of their proximity to fall hazards when working between the warning line and the unprotected sides and edges((~~, including the leading edge~~)) of a low pitch roof ((~~or other walking/working surface~~)).

(53) **Safety net system.** A type of fall arrest system, as described in WAC 296-880-40055.

(54) **Safety watch system.** A type of fall protection system in which a competent person is responsible for recognizing and warning one employee of a fall hazard.

(55) **Scaffold.** A temporary elevated platform, including its supporting structure and anchorage points, used for supporting employees or materials.

(56) **Self-propelled elevating work platform.** A self-propelled, integral chassis, elevating work platform with a platform that cannot be positioned completely beyond the base.

(57) **Self-rescue device.** A piece of equipment designed to allow a person, who is suspended in a personal fall arrest system, to independently rescue themselves after the fall by moving the device up or down until they reach a surface and are no longer suspended.

(58) **Self-retracting lifeline.** A deceleration device which contains a wound line which may be slowly extracted from, or retracted onto, the device under slight tension during normal employee movement, and which after onset of a fall, automatically locks the drum and arrests the fall.

(59) **Service.** To repair or provide maintenance for.

(60) **Shock absorbing lanyard.** A flexible line of webbing, cable, or rope used to secure a full body harness to a lifeline or anchorage point that has an integral shock absorber.

(61) **Snap hook.** See "locking snap hook."

(62) **Standard guardrail system.** A type of fall restraint system that is a vertical barrier consisting of a top rail and midrail, and toeboard when used as falling object protection for persons who may work or pass below, that is erected along all open sides or edges of a walking/working surface, ramps, platforms, or runways.

(63) **Standard strength and construction.** Any construction of guardrails, handrails, covers, or other guards that meets the requirements of this chapter.

(64) **Static line.** See "horizontal lifeline."

(65) **Steep pitched roof.** A roof having a slope greater than four in 12.

(66) **Structural member.** A support that is a constituent part of any building or structure. Structural members include columns, girders, beams, trusses, joists, and similar supporting members of a building or structure.

(67) **Suitable.** That which fits, or has the qualities or qualifications to meet a given purpose, occasion, condition, function, or circumstance.

(68) **Temporary.** The duration of the task the worker performs is brief or short.

(69) **Toeboard.** A vertical barrier at floor level erected along all open sides or edges of a floor opening, platform, runway, ramp, or other walking/working surface to prevent materials, tools, or debris from falling onto persons passing through or working in the area below.

(70) **Unprotected sides and edges.** Any open side or edge of a floor, roof, balcony/deck, platform, ramp, runway, or walking/working surface where there is no standard guardrail system, or parapet wall of solid strength and construction that is at least 39 inches in vertical height.

(71) **Walking/working surface.** Any surface, whether horizontal or vertical on which an employee walks, works, or gains access to a work area or workplace location. Walking/working surfaces include, but are not limited to, floors, the ground, roofs, ramps, bridges, runways, stairs, dockboards, formwork, and reinforcing steel but not including ladders.

(72) **Warning line system.** A barrier erected on a walking and working surface or a low pitch roof (four in 12 or less), to warn employees that they are approaching an unprotected fall hazard(s).

AMENDATORY SECTION (Amending WSR 22-19-082, filed 9/20/22, effective 11/1/22)

WAC 296-880-30005 Construction work. This section applies to work activities under the scope of chapter 296-155 WAC, Safety standards for construction work, unless specifically addressed in WAC 296-880-200 of this chapter.

(1) The employer must ensure that a fall arrest system, fall restraint system, or positioning device system is provided, installed, and implemented in accordance with WAC 296-880-400 Fall protection system specifications when employees are exposed to fall hazards of six feet or more to the ground or lower level while:

(a) Engaged in roofing work on a low pitched roof;

(b) Constructing a leading edge.

Exceptions: Employees not directly involved with constructing the leading edge, or are not performing roofing work must comply with WAC 296-880-200 Fall protection required at four feet or more.
A safety monitoring system may be used when engaged in roofing work on a low pitched roof.

(2) The employer must ensure that a fall arrest system, fall restraint system, or positioning device system is provided, installed, and implemented in accordance with WAC 296-880-400 Fall protection system specifications when employees are exposed to fall hazards of 10 feet or more to the ground or lower level while:

(a) Engaged in the erection or placement of structural members.

Exception: When the erection or placement of structural members is performed on or from a floor, deck, roof, or similar surface you must comply with WAC 296-880-200 Fall protection required at four feet or more.

(b) Engaged in excavation and trenching operations.

(i) Exceptions. Fall protection is not required at excavations when employees are:

(A) Directly involved with the excavation process and on the ground at the top edge of the excavation; or

(B) Working at an excavation site where appropriate sloping of side walls has been implemented as the excavation protective system.

(ii) Fall protection is required for employees standing in or working in the affected area of a trench or excavation exposed to a fall hazard of 10 feet or more; and:

(A) The employees are not directly involved with the excavation process; or

(B) The employees are on the protective system or any other structure in the excavation.

Note: Persons considered directly involved in the excavation process include:
1. Foreman of the crew.
2. Signal person.
3. Employee hooking on pipe or other materials.
4. Grade person.
5. State, county, or city inspectors inspecting the excavation or trench.
6. An engineer or other professional conducting a quality-assurance inspection.

(3) Employees are exempt from WAC 296-880-30005 under the following conditions:

(a) During initial installation of the fall protection anchor prior to engaging in any work activity, or the disassembly of the fall protection anchor after all work activities have been completed;

(b) When employees are inspecting, investigating, or assessing roof level conditions or work to be performed only on low pitch roofs prior to the start of construction work or after all construction work has been completed;

This exemption does not apply on steep pitch roofs, where construction work is underway, or when fall protection systems or equipment meeting the requirements of this chapter have been installed and

are available for workers to use for pre-work and post-work inspections, investigations, or assessments.

Note: Examples of activities the department recognizes as inspecting or estimating include:
• Measuring a roof to determine the amount of materials needed for a project;
• Inspecting the roof for damage without removing equipment or components; and
• Assessing the roof to determine what method of fall protection will be provided to employees.

Note: Examples the department does not recognize as inspecting or estimating under this exemption include:
• Delivering, staging, or storing materials on a roof; and
• Persons estimating or inspecting on roofs that would be considered a "hazardous slope" by definition.

(c) When employees must be located on vehicles, or rolling stock in order to perform their job duties.

AMENDATORY SECTION (Amending WSR 20-12-091, filed 6/2/20, effective 10/1/20)

WAC 296-880-40040 Warning line system requirements. Warning line systems and their use must conform to the following provisions:

Warning line system specifications used on roofs with a pitch of four in ((~~twelve~~)) 12 or less for roofing work, leading edge work and on low pitched open sided surfaces for work activities other than roofing work or leading edge work. The employer must ensure the following:

(1) Warning lines must be erected around all unprotected sides and edges of the work area.

(a) Warning lines used during roofing work:

(i) When roofing work is taking place or when mechanical equipment is not being used, the warning line must be erected not less than six feet (1.8 m) from the edge of the roof;

(ii) When mechanical equipment is being used, the warning line must be erected not less than six feet (1.8 m) from the roof edge which is parallel to the direction of mechanical equipment operation, and not less than ((~~ten~~)) 10 feet (3.1 m) from the roof edge which is perpendicular to the direction of mechanical equipment operation.

(b) Warning lines erected for leading edge work. Warning lines must be erected to separate employees who are engaged in leading edge work (between the forward edge of the warning line and the leading edge), from other work areas on the low pitched surface. The employer must ensure:

(i) The warning line is erected not less than six feet nor more than ((~~twenty-five~~)) 25 feet from the leading edge; and

(ii) ((~~When~~)) Fall arrest systems as described in WAC 296-880-40020((~~,~~)) or fall restraint systems as described in WAC 296-880-40025 ((~~are not used, the employer must implement a safety monitor system as described in WAC 296-880-40045~~)) must be used to protect employees engaged in constructing the leading edge ((~~who are working between the forward edge of the warning line and the leading edge~~)).

(c) Warning lines erected on low pitched open sided surfaces for work activities other than roofing work, or leading edge work must be erected not less than ((~~fifteen~~)) 15 feet from the unprotected sides or edges of the open sided surface.

(2) The warning line must consist of a rope, wire, or chain and supporting stanchions erected as follows:

(a) The rope, wire, or chain must be flagged at not more than six foot (1.8 m) intervals with high visibility material. Highly visible

caution or danger tape as described in (d) of this subsection, does not need to be flagged.

(b) The rope, wire, or chain must be rigged and supported in such a way that its lowest point (including sag) is no less than ((~~thirty-six~~)) 36 inches from the surface and its highest point is no more than ((~~forty-five~~)) 45 inches from the surface.

(c) After being erected, with the rope, wire or chain attached, stanchions must be capable of resisting, without tipping over, a force of at least ((~~sixteen~~)) 16 pounds (71 N) applied horizontally against the stanchion, ((~~thirty~~)) 30 inches (0.76 m) above the surface, perpendicular to the warning line, and in the direction of the unprotected sides or edges of the surface.

(d) The rope, wire, or chain must have a minimum tensile strength of ((~~five hundred~~)) 500 pounds (2.22 kN), and after being attached to the stanchions, must be capable of supporting, without breaking, the loads applied to the stanchions. Highly visible caution or danger tape may be used in lieu of rope, wire, or chain as long as it is at least three inches wide and three mils thick, and has a tensile strength of at least ((~~two hundred~~)) 200 pounds.

(e) The line must be attached at each stanchion in such a way that pulling on one section of the line between stanchions will not result in slack being taken up in adjacent sections before the stanchion tips over.

(3) The employer must erect access paths as follows:

(a) Points of access, materials handling areas, and storage areas must be connected to the work area by a clear access path formed by two warning lines.

(b) When the path to a point of access is not in use, the employer must place a rope, wire, or chain, equal in strength and height to the warning line, across the path at the point where the path intersects the warning line erected around the work area.

AMENDATORY SECTION (Amending WSR 20-12-091, filed 6/2/20, effective 10/1/20)

WAC 296-880-40045 Safety monitor system requirements. Safety monitor systems and their use must conform to the following provisions:

(1) A safety monitor system may be used in conjunction with a warning line system as a method of fall protection during roofing work on low pitched roofs ((~~or leading edge work on low pitched surfaces~~)).

Note: The warning line is not required when performing roofing work on low pitched roofs less than ((~~fifty~~)) 50 feet wide. For information on determining roof widths, see WAC 296-880-500, Appendix A, Determining roof widths.

(2) When selected, the employer must ensure that the safety monitor system is addressed in the fall protection work plan, including the name of the safety monitor(s) and the extent of their training in both the safety monitor and warning line systems. The employer must ensure that the following requirements are met:

(a) The safety monitor system must not be used when adverse weather conditions create additional hazards.

(b) Employees working outside of the warning line system, (between the forward edge of the warning line and the unprotected sides or edges of a low pitched surface), must be readily distinguishable from other members of the crew that are working inside the warning

line system by wearing highly visible, distinctive, and uniform apparel.

(c) Employees must promptly comply with fall hazard warnings from the safety monitor.

(d) The employer must train a person acting in the capacity of safety monitor(s) in the function of both the safety monitor and warning line systems, and they must:

(i) Be a competent person as defined in WAC 296-880-095;

(ii) Have control authority over the work as it relates to fall protection;

(iii) Be instantly distinguishable over members of the work crew;

(iv) Perform no other duties while acting as safety monitor;

(v) Be positioned in relation to the workers under their protection, so as to have a clear, unobstructed view and be able to maintain normal voice communication;

(vi) Not supervise more than eight exposed workers at one time; and

(vii) Warn the employee when it appears that the employee is unaware of a fall hazard or is acting in an unsafe manner.

WSR 24-18-119
PERMANENT RULES
TOBACCO SETTLEMENT AUTHORITY
[Filed September 4, 2024, 9:28 a.m., effective October 5, 2024]

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

Purpose: The tobacco settlement authority is repealing Title 465 WAC because the agency is dissolving pursuant to RCW 43.340.110.

Citation of Rules Affected by this Order: Repealing Title 465 WAC.

Statutory Authority for Adoption: RCW 43.340.110.

Adopted under notice filed as WSR 24-14-025 on June 25, 2024.

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

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

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 0, Repealed 16.

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

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

Date Adopted: September 4, 2024.

Steve Walker
Executive Director