

Issue	Decision	Rationale
Subsidy eligibility		
<ul style="list-style-type: none"> • Income Lock-in 	<ul style="list-style-type: none"> • Eligible partnership participants' incomes will be locked in from the date of enrollment through the plan contract year. • "Income lock-in" means that the subsidy percentage paid by the state (the percent of the employee's share of the premium) is also locked in. • Because the income and subsidy percentage are linked, even if the family's income or family size changes due to a qualifying event and the premium changes, the percentage of the employee's share remains constant. For example, if an employee's spouse loses other coverage and enrolls in the HIP outside of open enrollment, this would likely mean a higher premium. If the original subsidy determination put the subsidy percentage at 60% and the total employee share increased from \$300 to \$500 once the spouse is enrolled, the new subsidy amount would reflect the increase and be 60% of \$500—even if the loss of other coverage was the result of an income change (the spouse lost his or her job.) • The income lock-in also applies to nonsubsidized participants, unless they have had a change in circumstances. In these cases, those originally denied a subsidy or who did not apply because they knew they were ineligible will be allowed 	<ul style="list-style-type: none"> • HIP statutes do not require us to verify eligibility when participants' incomes change. • The lock-in period provides certainty and ease of administration. • Relieves the state of pursuing recoupment for over-subsidization in cases where there is an income change, which is costly and inefficient, based on the expected return.

	to apply for a subsidy, subject to the lock-in once enrolled.	
<ul style="list-style-type: none"> • Definition and verification of “income” 	<p>HIP’s income calculation process will be made as simple as possible.</p> <p>Definition of income:</p> <p>Income is defined as the total income as shown on the most recent tax year’s IRS 1040, 1040A, or 1040 EZ.</p> <p>Verification of income:</p> <p>To account for fluctuations in income and to arrive at an accurate subsidy calculation, the HIP will average income from the most recent tax year’s return.</p> <p>If the applicant didn’t file a return or has had a change in circumstances, HIP will require pay stubs for the past 90 days and will average the wages over three months.</p> <p>If the applicant didn’t file a return and can’t provide pay stubs for the past 90 days because of a change in circumstances, HIP will accept pay stubs for the past 30 days</p> <p>If the applicant cannot provide pay stubs for the most recent 30 days, the HIP will accept a signed, dated statement from the employer attesting that the wages given on the statement are representative of the employee’s average wages.</p> <p>The HIP will require a copy or transcript of the tax return, but not the attached Schedules. The TPA will calculate income for sole proprietors by averaging the amount shown on line 12 of the 1040 and for partners or S-Corp shareholders directly from Form 1040, line 17, averaged over</p>	<ul style="list-style-type: none"> • Neither the HIP statutes nor the budget proviso require us to count or exclude particular sources of money as income. • Based on the BH experience, income calculation is extremely complex and difficult for enrollees to understand and comply. • HIP is designed to serve a different (and smaller) population. • In the HIP, each employer group’s enrollment experience will be directly tied to each participant’s ability to provide the necessary documents. A delay on the part of a single participant could, depending on the group, delay the entire group’s enrollment. • BH experience has shown that for most unsuccessful applications, the inability to provide either a tax return or IRS transcript, or IRS proof of nonfiling is the most common cause for delayed or denied

	<p>12 months.</p> <p>One-time gambling/lottery winnings or lump sums received from inheritances will not be counted as income, although periodic payments from inheritances or estates will continue to be counted.</p> <p>The HIP will allow a deduction from income for child support payments.</p>	enrollment.
<ul style="list-style-type: none"> • Residence 	<p>The HIP will require participants to report changes in residence. Those found to no longer be state residents will lose their subsidy eligibility.</p>	<p>The statute is clear that residence is required for a subsidy.</p>
<ul style="list-style-type: none"> • Definition of “dependent” 	<ul style="list-style-type: none"> • The HIP will mirror the small group statutes and consider unmarried children as dependents up to age 25. For dependents aged 19 to 25, HIP will count their wages if they are included on the parents’ account, whether for coverage or family size. Dependents are not required to be enrolled for coverage to be included for family size for purposes of subsidy eligibility and calculation. . • The HIP will not require participants to list their young adult dependents for family size, but if they choose to do so, they are locked in to this choice until the anniversary date. • Domestic partners will not receive a subsidy. 	<ul style="list-style-type: none"> • This definition aligns with the small group market. • A BH-like definition that provides for full-time student status for young adults is difficult to administer and is only a snapshot in time— students move on and off FTS status quite regularly. • Both the TPA and the carriers can easily accommodate this process.

<p>Health plan open enrollment vs. subsidy eligibility and account changes</p>	<ul style="list-style-type: none"> • For health benefit plan enrollment, the HIP will establish procedures (and rules) consistent with HIPAA and Section 125 rules. • For subsidy eligibility or account changes, the HIP will treat these separately. 	
<p>Subsidy scale</p>	<ul style="list-style-type: none"> • No participant will receive a 100% subsidy. • The subsidy scale will consist of four income bands. • The state subsidy will pay a percentage of the employee's share of the premium after deducting the employer contribution, and including dependents. • The percentage the state pays is "anchored" to the original income calculation. Since the income is locked in from the date of enrollment in the HIP until the end of the plan year, if the premium increases (by adding family members) or decreases (by a reduction in family size), the total dollars subsidized will increase or decrease accordingly, but the percentage stays the same. • The subsidy percentage will range from 60% of the employee share for the highest income band to 90% of the employee share for the lowest income band. (Band A = 90%, Band B = 80%, Band C = 70%, and Band D = 60%.) • Subsidies capped at 90% of the 	<ul style="list-style-type: none"> • In relation to BH, HIP has a different mission and serves a different population. • BH has a fixed premium for the lowest three income bands. • Attempting to manipulate the subsidy scale to cause HIP to be more or less expensive for the state than BH would create enormous complexities and because of the variables involved (different benefit designs, the age of any particular group, employee choice, once implemented) makes it even more difficult to project with any degree of accuracy. • Fewer income bands will be easier to administer, particularly during the start-up phase. • Having limited income bands is consistent with early BH

	<p>benchmark rate.</p> <ul style="list-style-type: none"> • The employer contribution will be based on the benchmark plan, and must be at least 40%. • The benchmark plan will represent the median actuarial value, not the median price. • The subsidy scale and employer contribution mix are not intended to influence plan choice by employers or employees. 	<p>administration and can be revisited in the future as needed.</p> <ul style="list-style-type: none"> • Fewer income bands will result in less migration between income bands as participants renew coverage over time.
Portability/wait list	<ul style="list-style-type: none"> • COBRA-eligible employees who are receiving a subsidy when employment terminates will continue to receive a subsidy if otherwise eligible. • COBRA-eligible employees who are not receiving a subsidy but wish to apply for one because of a change in circumstances upon the loss of their job will bypass managed enrollment and will receive a subsidy, if otherwise eligible. • Nonsubsidized employees who either did not apply for or were denied a subsidy and then later experience a change in circumstances may apply for a subsidy and will bypass managed enrollment. 	<ul style="list-style-type: none"> • Consistent with Legislative intent regarding the value-add of portability. • Allowing these employees to enroll without waiting for space provides more certainty to employers.
Subsidy allocation	Subsidy dollars will be allocated in the following order	Based on Project Team meeting discussion, 06/30/08.

	<p>(1) Currently enrolled employer groups; then</p> <p>(2) COBRA participants; then</p> <p>(3) New employees and dependents of existing employer groups; then</p> <p>(4) New employer groups</p>	
Employer enrollment	<ul style="list-style-type: none"> • An employer may enroll in health insurance coverage through the HIP regardless of whether there are any subsidy-eligible employees enrolled or if enrollment is frozen due to limited funds, as long as the employer is otherwise eligible (not currently offering, at least 50% low-wage workers, etc.) • Employers enrolling under the conditions above may not enroll in other insurance coverage while waiting for subsidy funding. 	<ul style="list-style-type: none"> • Having subsidized employees is not an employer eligibility requirement, only that the employer have at least 50% low-wage workers • Employees are not required to apply for a subsidy, even if they know they're eligible for one.
Managed enrollment	<ul style="list-style-type: none"> • Enrollment will be managed at the group level • Once enrollment is closed, it is closed to all groups, regardless of size • Newly eligible employees (new hires) in a currently enrolled group may apply for a 	

	<p>subsidy and, if eligible, will have priority enrollment.</p> <ul style="list-style-type: none"> In forecasting enrollment, the HCA will hold a reserve of approximately five percent over the amount needed to subsidize each employer group through the end of the contract year. This reserve will be used to accommodate employee turnover and group size growth through the addition of new hires and new family members for enrolled participants. 	
Appeals	The definition of "appeal" in the rules is tightened to mean only appeals of HIP employer enrollment and subsidy determination, not to carrier or philanthropy decisions.	
Family changes	<p>Since income will be locked in until the next subsidy application and renewal period, there needs to be a written request to the TPA to add a family member that is not an "application", which would require proof of income. The rules require participants to "notify the administrator within 30 days of the change in family status, using the <i>required form.</i>"</p>	<ul style="list-style-type: none"> Based on Harington's suggestion Allows flexibility in developing the family change form without naming it in rule, yet still requires written request to add dependents, both inside and outside open enrollment.
Benchmark plan	<ul style="list-style-type: none"> The designated health benefit plan tiers are broken down by actuarial 	The decisions listed in this section will need to be addressed

	<p>value, but each tier is further defined by the parameters as indicated in the 06/05/08 Board Motion. If, for example, a carrier submits a plan at or below the current mid-range, for example, just above or below it, and yet still met the parameters, would this plan still be eligible for offer through the HIP?</p> <ul style="list-style-type: none"> • Could the average or “mean” upon which the benchmark is based be adjusted when new plans come in or are closed? If so, this could mean an eventual erosion of the plan values over time if the carriers continue to offer increasingly lean benefit plans. • Since the benchmarks are carrier-specific, what if a particular carrier wants to offer through the HIP, but doesn’t have a mid-range plan that falls within the actuarial range (or does fall within, yet doesn’t meet the parameters approved by the Board? 	<p>by the Board.</p>
<p>Philanthropies</p>	<ul style="list-style-type: none"> • The rules will not define or refer to “financial sponsors.” • The HIP will allow philanthropies to contribute toward a nonsubsidized partnership participant’s employee premium obligation. • Establishes a mechanism for philanthropies to contribute either to: <ul style="list-style-type: none"> ▪ Specific employer groups, i.e., all eligible 	<ul style="list-style-type: none"> • “Financial sponsor” is not defined in statute. • Avoids the comparison to the BH model

	<p>employees enrolled through ABC Widget Company, or</p> <ul style="list-style-type: none"> ▪ Specific individuals meeting the philanthropy's eligibility criteria, i.e., eligible MS patients, religious organizations for congregants, etc. In these cases, the philanthropy would determine individuals' eligibility and would enter into an agreement with the HIP to contribute toward the participants' premium obligation, after the application of the state subsidy and, if applicable, the employer contribution. • Philanthropies may also make a block grant to the HIP to assist any subsidy-eligible partnership participant. In these cases, the HIP does not commit to applying the grant dollars toward a specific individual, class, or employer group. <ul style="list-style-type: none"> ○ In either case (individual or grant), we will need written agreements with the philanthropy. For the individual contribution, the agreement would need to clearly indicate the philanthropy's eligibility criteria. <ul style="list-style-type: none"> • The TPA will administer philanthropic contributions, through a written agreement with the HIP. • The written agreement will require a philanthropy that contributes to an employer group or class of enrollees to provide written notice when the philanthropy intends to discontinue contributions (unless for nonpayment of premium.) • For individual philanthropy contributions, 	
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	<p>Harrington will bill the philanthropy and will include the contribution when making payment to the carriers</p> <p>Payroll:</p> <ul style="list-style-type: none"> ▪ Employer contribution ▪ EE obligation ▪ Subsidy ▪ Harrington bills the philanthropy for the remaining portion ▪ Harrington submits entire amount to the carrier <p>COBRA:</p> <ul style="list-style-type: none"> ▪ EE Obligation ▪ Subsidy ▪ Philanthropy 	
<p>Delinquency/reinstatement/NSF payments</p>	<ul style="list-style-type: none"> • The HIP will not reinstate employer groups disenrolled for nonpayment. • An employer group disenrolled from the HIP will not automatically disenroll from insurance coverage, but to continue coverage, must comply with the reinstatement and employer contribution terms set out in the contract. • Employers are responsible for contacting the carrier to explore their options and the requirements for reinstatement. • An employer group may reapply for the HIP under the same conditions as the original enrollment (new Employer Agreement form, can't currently offer coverage, over 50% low-wage workers.) 	<ul style="list-style-type: none"> • While the HIP does have the authority to disenroll employer groups from the HIP due to nonpayment, it does not have the authority to disenroll employer groups from insurance coverage. • Once an employer group is no longer enrolled through the HIP, the group must comply with the standard terms of the insurance contract, i.e., meet the minimum employer contribution, comply with the reinstatement terms. • Carriers will not automatically lose the group's business if the group loses its HIP eligibility, and may

	<p>Employees must also reapply for the subsidy. TBD: The maximum length of disenrollment before employees must send new supporting documents.</p> <ul style="list-style-type: none"> • The monthly due date will be the 10th, with a 5-day “grace” period. If the group fails to make the payment by the final due date, the TPA will send a disenrollment letter to the employer group and individual letters to the subsidized employees, along with a notification to the carrier. In the interim between the first notice sent to the employer and the final due date, subsidized enrollees will receive a letter from the TPA to alert them that their subsidy is in jeopardy, along with referrals to other state-funded programs, such as BH or Medicaid. • 	<p>be able to maintain some of these accounts.</p> <ul style="list-style-type: none"> • The early due date may initially be a problem for some employer groups, but the additional time will provide a cushion for groups who wish to continue with coverage in the event of the loss of the subsidy. <hr/>
<p>HIP Appeals</p>	<ul style="list-style-type: none"> • The HIP must receive an appeal within 30 days of the decision being appealed. • Within 15 days of receiving an appeal, the TPA will send the appealing party a confirmation letter. • Within 60 days receiving an appeal, the HIP will send the appealing party its decision. • Pending the decision of an appeal, neither employer groups nor individual participants will have the option to continue coverage—coverage ends as of 	<ul style="list-style-type: none"> • TBD: If an appeal is granted, how will the HIP restore eligibility and the subsidy? • For existing employer groups who successfully appeal, will the carriers be willing to restore eligibility under the same conditions as originally enrolled, i.e., reduced employer contribution?

	the date given in the decision letter, unless the appeal is granted.	
Continuation coverage	<ul style="list-style-type: none"> The HIP will not subsidize continuation coverage, except as required for COBRA-eligible participants 	<ul style="list-style-type: none"> Not required under current law, but will be implemented when individual choice is introduced.
Recoupment	<p>The HIP will initiate recoupment under the following scenarios:</p> <ul style="list-style-type: none"> When an applicant or participant fails to report existing sources and amounts of income at application or subsidy renewal. When a participant fails to report a change of address (out of state.) Following an appeal, if the results of the appeals process show an oversubsidy. In these cases, the HIP will recoup the oversubsidy paid and adjust the account going forward. Accounts in recoupment status will still be eligible to receive a subsidy. 	<ul style="list-style-type: none"> Because of the income lock-in, the HIP will not penalize participants whose incomes increase after enrollment, but will adjust their incomes going forward at subsidy renewal. In most cases, the HIP won't know of a failure to report income existing at the time of enrollment until the next subsidy renewal period, when the income is likely to show on the succeeding year's tax return. Because of the minimum participation requirement, the HIP will not deny current subsidies for participants who owe for recoupment, so as not to "penalize" the group for the individual's failure to report income or residence status.

Employer enrollment, annual renewal, attestation	<ul style="list-style-type: none"> • A participating small employer will be required to sign the Employer Agreement form only at initial enrollment, and not at subsequent renewal. • 	<ul style="list-style-type: none"> • The enabling legislation does not provide the authority or parameters for anything other than initial enrollment. • The language in the bill requires the employer to attest that he or she does not currently offer coverage. An employer already enrolled in the HIP would not be able to attest to this. • If an employer experiences a temporary dip in employee census that corresponds with the subsidy renewal, this could result in the loss of HIP eligibility.

Chapter 182-26 WAC

WASHINGTON HEALTH INSURANCE PARTNERSHIP (HIP) PROGRAM

NEW SECTION

WAC 182-26-010 Authority. The administrator's authority to make rules is contained in RCW 70.47A.060.

NEW SECTION

WAC 182-26-020 Definitions--Generally. Unless the context clearly indicates otherwise, the definitions in Part 1 of this chapter apply throughout this chapter.

**PART 1
DEFINITIONS**

NEW SECTION

WAC 182-26-100 Definitions. "Administrator" means the administrator of the Washington state health care authority established under chapter 41.05 RCW.

"Appeal" means a formal written request to the HIP or its designee for resolution of problems or concerns that cannot be resolved informally. For the purposes of this chapter, "appeal" applies only to HIP decisions regarding subsidy determinations and employer eligibility for the HIP.

"Applicant" means:

- An individual who applies for a premium subsidy through the HIP on behalf of the individual and his or her dependents; or

● A partnership participant who applies or reapplies for premium subsidy through the HIP on behalf of the partnership participant and his or her dependents during the annual subsidy application and renewal period as described in WAC 182-26-320.

"Application" means a form developed by the administrator that an applicant must sign, complete, and submit to the administrator to apply for a premium subsidy through the HIP. To be considered complete, the application must be accompanied by all supporting documents as required and determined by the administrator.

"Benchmark health benefit plan" or "benchmark plan" means a health benefit plan selected by the board and upon which the subsidy scale shall be determined and from which the administrator will calculate a partnership participant's premium subsidy.

"Board" or "HIP board" means the health insurance partnership board established under RCW 70.47A.100.

"Carrier" or "insurance carrier" means the same as defined in RCW 48.43.005.

"The department of social and health services" or "DSHS" means the department of social and health services as defined in RCW 43.20A.020.

"Dependent," for the purpose of determining subsidy eligibility, "dependent" means:

(1) A partnership participant's lawful spouse, not legally separated, who shares a home with the partnership participant; or

(2) The unmarried child of the partnership participant or participant's dependent spouse, whether by birth, adoption, legal guardianship, or placement pending adoption, and not given up for adoption, who is:

(a) Younger than age twenty-five; or

(b) Is of any age, is not able to take care of himself or herself due to disability, and is under legal guardianship of the partnership participant or the participant's dependent spouse.

(3) A dependent may be placed on only one HIP account at any given time.

"Designated health benefit plan" means a health benefit plan selected by the board as eligible for offer through the HIP.

"Disenroll" or "disenrollment" means the termination of a partnership participants' enrollment in the HIP program. Decisions regarding eligibility or enrollment status for insurance coverage will be made by the carrier.

"Eligible partnership participant" means a partnership participant who:

● Is a resident of the state of Washington;

● Has a family income that does not exceed two hundred percent of the federal poverty level, as determined annually by the federal Department of Health and Human Services; and

● Is a health plan eligible employee as defined in this section that is enrolled or is applying to enroll in the participating small employer's offered coverage.

"Employee" has the same meaning as defined in RCW 48.43.005.

"Employer agreement" means a form developed by the administrator that a small employer must complete, sign, and submit

to the administrator to request enrollment in the HIP.

"Health insurance partnership" or "HIP" means the health insurance partnership established in RCW 70.47A.030.

"Health plan eligible employee" means an individual who meets the participating small employer's enrollment criteria.

"HIP account" means an account maintained by the administrator for each partnership participant that includes but is not limited to:

- Demographic information for participants and dependents, if any;
- Subsidy status;
- Carrier and plan enrollment status; and
- Other information as required by the administrator.

"Income" or "family gross income" means total cash receipts, as defined in WAC 182-26-345, before taxes, for participants and all dependents.

"Individual health benefit plan selection." Reserved.

The "office of the insurance commissioner" or "OIC" means the insurance commissioner as defined in RCW 48.02.010.

"Open enrollment" means a designated time period during which partnership participants may enroll additional dependents or make other changes to their employer-sponsored health benefit plan coverage.

"Participating small employer" means a small employer who:

- Enters into a written agreement with the HIP to purchase a designated health benefit plan through the HIP;
- Attests at the date of the agreement that the employer does not currently offer coverage, including insurance purchased through the small group and association health plan markets, self-funded plans, and multiple employer welfare arrangements; and
- Attests at the date of the agreement that at least fifty percent of its employees are low-wage workers, as defined by the board.

"Partnership participant" means:

- A participating small employer as defined in this section;
- An employee of a participating small employer;
- A former employee of a participating small employer who chooses to continue coverage through the HIP following separation from employment, to the extent the employee is eligible for continuation of coverage under 29 U.S.C. Sec. 1161 et seq.; and
- A former employee of a participating small employer who chooses to continue coverage through HIP following separation from employment, to the extent determined by the board.

"Philanthropy" means a person, organization or other entity, approved by the administrator that is responsible for payment of all or part of the monthly premium obligation on behalf of a partnership participant.

"Premium" has the same meaning as described in RCW 48.43.005.

"Premium subsidy" or "subsidy" means payment to or reimbursement by the HIP on behalf of an eligible partnership participant toward the purchase of a designated health benefit plan.

"Qualifying change in family status" is defined in WAC 182-26-325.

"Section 125 plan" means a cafeteria plan compliant with section 125 of the federal Internal Revenue Code that enables employees to use pretax dollars to pay their share of their health benefit plan premium.

"Small employer" or "employer" as used in this chapter means an employer who meets the definition of "small employer" in RCW 48.43.005.

"Subsidy application and renewal period" means an annual period that lasts at least sixty days, during which:

- All partnership participants may apply for premium subsidies for themselves and their dependents; and

- All partnership participants receiving a subsidy are required to provide proof of their continuing eligibility for a premium subsidy.

The subsidy application and renewal period will begin ninety days before the employer-sponsored health benefit plan open enrollment period begins.

"Surcharge" means an amount, determined by the administrator, that may be added to a partnership participant's premium as provided for in WAC 182-26-500. The surcharge is not part of the premium and applies only to coverage purchased through the HIP.

"Washington state resident" means:

(a) A person who physically resides in and maintains a residence in the state of Washington.

(b) To be considered a Washington resident, individuals who are temporarily out of Washington state for any reason may be required to demonstrate their intent to return to Washington state.

(c) "Residence" may include, but is not limited to:

(i) A home the person owns or is purchasing or renting;

(ii) A shelter or other physical location where the person stays; or

(iii) Another person's home.

PART 2 EMPLOYER ENROLLMENT

NEW SECTION

WAC 182-26-200 Employer eligibility for the HIP. To enroll in the HIP, a small employer must:

- Meet the minimum contribution requirement under WAC 182-26-210;

- Meet the minimum participation requirement under WAC 182-26-220; and
- Agree to establish a section 125 plan under RCW 70.47A.030 (2) (a).

NEW SECTION

WAC 182-26-210 Minimum employer contribution.

- A small employer must contribute at least forty percent of each health plan eligible employee's total premium obligation.
- The minimum contribution requirement does not apply to a health plan eligible employee's dependent's premium.

NEW SECTION

WAC 182-26-220 Minimum participation.

- A participating small employer will determine the criteria for eligibility and enrollment in his or her designated health benefit plan.
- To participate in the HIP, the small employer must enroll at least seventy-five percent of the health plan eligible employees in the designated health benefit plan.
- When calculating the minimum participation percentage, employees who have similar existing coverage from another source and the health plan eligible employees' dependents will not be included.

**PART 3
PREMIUM SUBSIDIES**

NEW SECTION

WAC 182-26-300 Who can receive a premium subsidy? An eligible partnership participant may receive a premium subsidy if there is sufficient funding available, as determined by the administrator.

NEW SECTION

WAC 182-26-305 Applying for a HIP premium subsidy. (1) To receive a HIP subsidy, an applicant must submit a complete application and all supporting documents as described in WAC 182-26-310 to the HIP.

(2) On a subsidy application, an applicant must list all eligible dependents up to age nineteen. The applicant must also provide other information and documents as required by the HIP.

(3) An applicant is not required to list dependents aged nineteen or over and under twenty-five on the application, but if they are listed on the application, the HIP will include the dependents' income for purposes of subsidy eligibility and calculation.

(4) An applicant is not required to apply for a subsidy for all of his or her dependents. However, any dependent that does not apply for a subsidy at the same time that the other family members apply must wait to apply as a dependent until the next subsidy application and renewal period.

NEW SECTION

WAC 182-26-310 Application--Supporting documents. (1) An application for a HIP subsidy must be accompanied by all of the following supporting documents:

- Proof of the family gross income as described in WAC 182-26-345.

- Proof of the applicant's Washington state residence, displaying the applicant's name and current address, such as a utility bill or rent receipt. The HIP may accept other documents if the applicant does not have a physical residence, for example, a signed statement from a person or other entity that is providing temporary shelter. The HIP will not accept a post office box or other mailing address as proof of residence.

- Other documents or information as requested by the HIP to establish or verify eligibility.

(2) The HIP may verify income of applicants for a HIP subsidy through comparison with other state and federal agency records or other third-party sources.

(3) Incomplete or inaccurate information may delay or prevent an applicant from receiving a premium subsidy. Intentionally submitting false information will, at a minimum, result in the loss of subsidy eligibility for an applicant or partnership participant

and all of his or her subsidized dependents.

NEW SECTION

WAC 182-26-315 HIP application review. (1) Except as provided in WAC 182-26-300, the HIP will review subsidy applications within thirty days of receipt. The HIP will send notification of an applicant's subsidy status upon completion of the review.

(2) Eligible applicants will be subsidized in the HIP in the order in which their completed applications have been received by the HIP, provided the administrator has determined there is subsidy funding available and the participating small employer also remits full payment of the first full month's premium to the HIP by the due date specified by the HIP.

NEW SECTION

WAC 182-26-320 Annual subsidy application and renewal. (1) The HIP will verify the continuing eligibility of eligible partnership participants at least annually, or upon renewal or a change of the employer-sponsored health benefit plan.

(2) Upon request of the HIP, subsidized eligible partnership participants must submit evidence satisfactory to the HIP that proves their continued eligibility for a premium subsidy and for the amount of subsidy they receive.

(3) The HIP may verify income of subsidized eligible partnership participants through comparison with other state and federal agency records or other third-party sources.

(4) If the eligible partnership participant's income on record with other agencies or third-party sources differs from the income the participant has reported to the HIP, or if questions arise concerning the documents submitted, the HIP may require updated documents from the participant to prove continued eligibility for the subsidy they receive. At that time, the HIP may also require updated proof of residence.

(5) Eligible partnership participants who have documented that they did not file a federal income tax return for previous years may not be required to provide additional verification of nonfiling, unless their circumstances appear to have changed or other information received by the HIP indicates they may have filed a federal income tax return.

(6) In addition to verification of income, eligible partnership participants must annually submit proof of Washington

state residence to the HIP.

(7) Partnership participants who fail to comply with an annual subsidy renewal request will be disenrolled from the HIP subsidy program and will no longer receive a premium subsidy from the HIP.

(8) If, as the result of an annual subsidy renewal review, the HIP determines that a partnership participant has not reported income accurately, the partnership participant will be subject to the provisions of WAC 182-26-335.

NEW SECTION

WAC 182-26-325 Making changes to a HIP account. (1) A partnership participant may add an eligible dependent to a HIP account:

(a) Annually, during the subsidy application and renewal period; or

(b) When there is a qualifying change in family status. In these cases, the partnership participant must notify the administrator on the required form within thirty calendar days of the change in family status. A "qualifying change in family status" means:

- The loss of other health care coverage for a dependent who has previously waived coverage in the partnership participant's employer-sponsored health benefit plan;

- The birth, adoption, or placement for adoption of a dependent child in the partnership participant's home;

- The partnership participant marries;

- The partnership participant or his or her spouse assumes custody or dependency of a child or adult dependent; or

- A dependent that was previously ineligible for the partnership participant's employer-sponsored health benefit plan coverage has become eligible.

(2) A partnership participant may remove dependents from a HIP account upon divorce, annulment, or legal separation, or upon the death of a dependent. In these cases, the partnership participant must notify the HIP within thirty calendar days of the change in family status.

(3) A partnership participant must notify the HIP of a change in his or her physical address within thirty calendar days of the change of address.

NEW SECTION

WAC 182-26-330 Loss of subsidy eligibility. A partnership participant may lose subsidy eligibility for himself or herself and his or her dependents when:

- The partnership participant's or dependent's coverage under his or her designated health benefit plan has been suspended or terminated;
- The partnership participant is no longer a Washington state resident;
- The partnership participant has not accurately reported his or her family gross income at the time of subsidy application or renewal; or
- The partnership participant's employer is disenrolled from the HIP program.

If the partnership participant loses subsidy eligibility, he or she will no longer receive a premium subsidy, beginning with the next coverage month following the determination of the change.

NEW SECTION

WAC 182-26-335 Recoupment. The HIP may recoup overpaid subsidy amounts from current and former partnership participants when the HIP determines that a subsidy overpayment occurred because the current or former partnership participant misrepresented or withheld information necessary to accurately determine their subsidy eligibility or subsidy amount.

NEW SECTION

WAC 182-26-340 How does the HIP determine the premium subsidy amount? (1) The HIP will apply a sliding scale subsidy schedule based on the partnership participant's family gross income and family size to determine the percentage of the employee's premium obligation the state will pay.

(2) The percentage in subsection (1) of this section will be applied to the health benefit plan employee premium share, including the amount due for dependents' coverage, remaining after deducting the employer contribution from the total premium amount for that participant.

(3) If a participating small employer chooses a health benefit plan with a higher premium than the benchmark plan, the subsidy will not exceed the amount applicable to the benchmark plan.

(4) In no case will the subsidy percentage exceed ninety

percent of the benchmark plan employee premium share.

(5) Once enrolled in the HIP, the subsidy percentage will not change until the next subsidy application and renewal period, even if the total premium share changes because of a qualifying change in family status.

NEW SECTION

WAC 182-26-345 How does the HIP calculate income? (1) The HIP will average applicants' or dependents' family gross income over a twelve-month period using the total income reported on the most recent tax year's federal income tax return.

(2) If the applicant or dependent cannot provide a copy or IRS transcript of the most recent tax year's federal income tax return, the applicant or dependent must submit a signed declaration of nonfiling and the HIP will calculate the income based on documents deemed acceptable to the administrator.

(3) If an applicant or his or her spouse is self-employed or receives rental income, the applicant or spouse may be required to submit a twelve-month history of receipts and expenses for proof of self-employment or rental income unless the applicant or spouse has not owned the business or rental for at least twelve months. In these cases, the applicant or spouse must send proof of all receipts and expenses for all months he or she has owned the business or rental.

(4) The HIP will deduct expenses an applicant or spouse pays for child or dependent care when calculating family income. The HIP will establish a maximum amount that can be deducted, consistent with IRS requirements. To qualify for this deduction:

(a) The care must be for a dependent on the account, as described under "dependent" as defined in WAC 182-26-100;

(b) The applicant and spouse, if any, listed on the account, must be employed, attend school, or be receiving Social Security disability benefits during the months the care was provided; and

(c) The person who was paid for the dependent's care cannot be the dependent's parent or stepparent or another of the applicant's or spouse's dependents.

(5) The HIP will deduct payments made for alimony when calculating family income.

NEW SECTION

WAC 182-26-350 What does the HIP count as income? Income includes all of the following, before any deductions (gross income):

Source	Received by the participant, spouse, child dependent aged nineteen or over and under twenty-five, or adult dependent	Received by a dependent child under age nineteen
Wages, tips, and salaries	Yes	No
Taxable interest	Yes	Yes
Ordinary dividends	Yes	Yes
Taxable refunds, credits, or offsets of state and local income taxes	Yes	Yes
Alimony received	Yes	N/A
Business income or loss	Yes	Yes
Capital gain or loss	Yes	Yes
Other gains or losses	Yes	Yes
IRA distributions	Yes	Yes
Pensions and annuities	Yes	N/A
Rental real estate, royalties, partnerships, S corporations	Yes	Yes
Farm income	Yes	Yes
Unemployment compensation	Yes	No
Social Security benefits	Yes	Yes
Other income	Yes	Yes

**PART 4
ADMINISTRATIVE PROCEDURES**

NEW SECTION

WAC 182-26-400 Appeals--Grounds. (1) An employer may appeal a HIP decision regarding the employer group's eligibility or enrollment status in the HIP.

(2) A partnership participant or applicant may appeal a HIP decision regarding:

- Eligibility for a premium subsidy;
- Premium subsidy amounts;
- Premium subsidy adjustments or penalties.

NEW SECTION

WAC 182-26-405 Appeals--Who may appeal a HIP decision? The HIP will accept appeals from an appealing party. For the purposes of this chapter, "appealing party" means:

(1) A participating small employer or small employer who has been denied enrollment in the HIP;

(2) An eligible partnership participant or applicant; or

(3) A third party on the behalf of the person listed in subsection (1) or (2) of this section, as long as the HIP has authorization from the person appealing. The authorization must:

- Be in writing; and
- Verify that the third party represents the person appealing, and that the HIP can share the person's HIP account information with the third party.

NEW SECTION

WAC 182-26-410 How to appeal a HIP decision. (1) To appeal a HIP decision, submit a signed letter of appeal to the HIP. The HIP must receive the letter of appeal within thirty calendar days of the date of the decision. The letter of appeal should include:

(a) The appealing party's name, mailing address, and HIP account number if assigned;

(b) A copy of the notice of the decision being appealed or an explanation of the decision being appealed; and

(c) A statement explaining why the appealing party believes the decision was incorrect, outlining the facts surrounding the decision and including supporting documents.

(2) If an appealing party would like an opportunity to explain in person or by phone, the appealing party should include that in the letter of appeal.

(3) Within fifteen calendar days of the date the HIP receives

the letter of appeal, the HIP will send the appealing party written confirmation of receipt of the appeal. If requested by the appealing party, the HIP will schedule an opportunity for the appealing party to explain in person or by phone.

(4) Within sixty calendar days of the date the HIP receives the letter of appeal, the HIP will send the appealing party written notice of the HIP appeal decision. If the appeal is from a third party, the HIP will send a copy of the notice to the appealing party. The notice will include the reasons for the appeal decision and instructions for requesting a review of the appeal decision.

(5) The appeal decision becomes the final agency decision unless the HIP receives a valid request for an additional review from the appealing party. To be valid the request must:

- Be received by the HIP within thirty calendar days of the date of the appeal decision;
- Include a summary of the decision to be reviewed and explain why the appealing party believes the decision was incorrect; and
- Provide additional information or documents the appealing party would like the HIP to consider in the review.

(6) When a valid request for an additional review is received, HIP appeal decisions will be reviewed by a presiding officer according to the requirements of RCW 34.05.488 through 34.05.494. These review decisions will be based on the record and documents submitted, unless the presiding officer decides that an in-person or telephone hearing is needed. If an in-person or telephone hearing is needed, the presiding officer will decide whether to conduct the hearing as an informal hearing or formal adjudicative proceeding.

(7) The presiding officer will send a written notice of the review decision, including the reasons for the decision, within twenty-one calendar days of receiving the request for review, unless the presiding officer finds that additional time is needed for the decision.

(8) If the appealing party disagrees with a review decision under subsection (5) of this section, he or she may request judicial review of the decision, as provided for in RCW 34.05.542.

PART 5
AGENCY OPERATIONS

NEW SECTION

WAC 182-26-500 Surcharge applicability. (1) The HIP may apply the surcharge uniformly to each health benefit plan purchased through the HIP to reflect the HIP's administrative and operational expenses remaining after any legislative appropriation for this purpose during the year the surcharge is assessed.

(2) The surcharge may be added to the premium, but will not be considered a part of the small group community rate and applies only to coverage purchased through the HIP.

(3) The surcharge may not be used to pay any premium assistance payments.