H-0484.1

HOUSE BILL 1361

State of Washington 62nd Legislature 2011 Regular Session

By Representatives Schmick, Hinkle, Bailey, McCune, Warnick, Short, Haler, Taylor, Kristiansen, Angel, Johnson, Condotta, and Klippert

Read first time 01/19/11. Referred to Committee on Health Care & Wellness.

AN ACT Relating to eliminating mandated health care benefits under state law; amending RCW 48.43.045; reenacting and amending RCW 48.43.005; adding a new section to chapter 48.43 RCW; creating a new section; and repealing RCW 48.02.062, 48.20.385, 48.20.390, 48.20.391, 48.20.392, 48.20.393, 48.20.395, 48.20.397, 48.20.410, 48.20.411, 48.20.414, 48.20.416, 48.20.418, 48.20.420, 48.20.430, 48.20.490, 48.20.520, 48.20.580, 48.21.125, 48.21.130, 48.21.140, 48.21.141, 48.21.143, 48.21.144, 48.21.146, 48.21.148, 48.21.150, 48.21.155, 48.21.160, 48.21.180, 48.21.190, 48.21.195, 48.21.197, 48.21.200, 48.21.220, 48.21.225, 48.21.227, 48.21.230, 48.21.235, 48.21.241, 48.21.250, 48.21.260, 48.21.270, 48.21.280, 48.21.300, 48.21.310, 48.21.320, 48.21A.090, 48.42.100, 48.43.017, 48.43.041, 48.43.043, 48.43.093, 48.43.115, 48.43.125, 48.43.180, 48.43.185, 48.43.190, 48.44.212, 48.44.225, 48.44.240, 48.44.245, 48.44.290, 48.44.300, 48.44.305, 48.44.315, 48.44.320, 48.44.325, 48.44.327, 48.44.330, 48.44.335, 48.44.341, 48.44.344, 48.44.360, 48.44.370, 48.44.380, 48.44.400, 48.44.420, 48.44.440, 48.44.460, 48.44.500, 48.46.250, 48.46.272, 48.46.275, 48.46.277, 48.46.280, 48.46.285, 48.46.291, 48.46.350, 48.46.355, 48.46.375, 48.46.440, 48.46.450, 48.46.460, 48.46.480, 48.46.490, 48.46.510, 48.46.520, 48.46.530, 48.46.570, 48.46.580, 48.125.200, and 48.43.515.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** The legislature finds that health carriers in Washington are currently subject to a variety of mandated benefits under state law, some of which are required by federal law. The legislature further finds that the mandated health care benefits provided under federal law adequately protect consumers. Furthermore, under the federal patient protection and affordable care act and the health care and education reconciliation act of 2010, health carriers will be required to offer essential health benefits. These new federal requirements, along with existing state mandates that may possibly conflict and overlap with the federal mandates, will make the regulatory landscape for health carriers confusing and difficult to implement. State mandated benefits that exceed the essential health benefits may also result in increased costs for the state as it implements federal health care reform. It is therefore the intent of the legislature to repeal all state mandated benefits and replace them with a requirement that health carriers comply with federal mandates.

NEW SECTION. **Sec. 2.** A new section is added to chapter 48.43 RCW to read as follows:

All health plans offered in this state must include all benefits required by federal law.

Sec. 3. RCW 48.43.005 and 2010 c 292 s 1 are each reenacted and amended to read as follows:

Unless otherwise specifically provided, the definitions in this section apply throughout this chapter.

(1) "Adjusted community rate" means the rating method used to establish the premium for health plans adjusted to reflect actuarially demonstrated differences in utilization or cost attributable to geographic region, age, family size, and use of wellness activities.

(2) "Basic health plan" means the plan described under chapter 70.47 RCW, as revised from time to time.

(3) "Basic health plan model plan" means a health plan as required in RCW 70.47.060(2)(e).

(4) "Basic health plan services" means that schedule of covered

health services, including the description of how those benefits are to be administered, that are required to be delivered to an enrollee under the basic health plan, as revised from time to time.

(5) "Catastrophic health plan" means:

(a) In the case of a contract, agreement, or policy covering a single enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, one thousand seven hundred fifty dollars and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least three thousand five hundred dollars, both amounts to be adjusted annually by the insurance commissioner; and

(b) In the case of a contract, agreement, or policy covering more than one enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, three thousand five hundred dollars and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least six thousand dollars, both amounts to be adjusted annually by the insurance commissioner; or

(c) Any health benefit plan that provides benefits for hospital inpatient and outpatient services, professional and prescription drugs provided in conjunction with such hospital inpatient and outpatient services, and excludes or substantially limits outpatient physician services and those services usually provided in an office setting.

In July 2008, and in each July thereafter, the insurance commissioner shall adjust the minimum deductible and out-of-pocket expense required for a plan to qualify as a catastrophic plan to reflect the percentage change in the consumer price index for medical care for a preceding twelve months, as determined by the United States department of labor. The adjusted amount shall apply on the following January 1st.

(6) "Certification" means a determination by a review organization that an admission, extension of stay, or other health care service or procedure has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.

(7) "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

(8) "Covered person" or "enrollee" means a person covered by a health plan including an enrollee, subscriber, policyholder, beneficiary of a group plan, or individual covered by any other health plan.

(9) "Dependent" means, at a minimum, the enrollee's legal spouse and unmarried dependent children who qualify for coverage under the enrollee's health benefit plan.

(10) ((~~"Emergency medical condition" means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.~~

~~(11) "Emergency services" means otherwise covered health care services medically necessary to evaluate and treat an emergency medical condition, provided in a hospital emergency department.~~

~~(12)~~)) "Employee" has the same meaning given to the term, as of January 1, 2008, under section 3(6) of the federal employee retirement income security act of 1974.

((~~(13)~~)) (11) "Enrollee point-of-service cost-sharing" means amounts paid to health carriers directly providing services, health care providers, or health care facilities by enrollees and may include copayments, coinsurance, or deductibles.

((~~(14)~~)) (12) "Grievance" means a written complaint submitted by or on behalf of a covered person regarding: (a) Denial of payment for medical services or nonprovision of medical services included in the covered person's health benefit plan, or (b) service delivery issues other than denial of payment for medical services or nonprovision of medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier.

((~~(15)~~)) (13) "Health care facility" or "facility" means hospices licensed under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW, rural health care facilities as defined in RCW 70.175.020, psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes licensed under chapter 18.51 RCW, community mental health centers licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment

centers licensed under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical facilities licensed under chapter 70.41 RCW, drug and alcohol treatment facilities licensed under chapter 70.96A RCW, and home health agencies licensed under chapter 70.127 RCW, and includes such facilities if owned and operated by a political subdivision or instrumentality of the state and such other facilities as required by federal law and implementing regulations.

((~~(16)~~)) (14) "Health care provider" or "provider" means:

(a) A person regulated under Title 18 or chapter 70.127 RCW, to practice health or health-related services or otherwise practicing health care services in this state consistent with state law; or

(b) An employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment.

((~~(17)~~)) (15) "Health care service" means that service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease.

((~~(18)~~)) (16) "Health carrier" or "carrier" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, or a health maintenance organization as defined in RCW 48.46.020.

((~~(19)~~)) (17) "Health plan" or "health benefit plan" means any policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care services except the following:

(a) Long-term care insurance governed by chapter 48.84 or 48.83 RCW;

(b) Medicare supplemental health insurance governed by chapter 48.66 RCW;

(c) Coverage supplemental to the coverage provided under chapter 55, Title 10, United States Code;

(d) Limited health care services offered by limited health care service contractors in accordance with RCW 48.44.035;

(e) Disability income;

(f) Coverage incidental to a property/casualty liability insurance policy such as automobile personal injury protection coverage and homeowner guest medical;

(g) Workers' compensation coverage;

(h) Accident only coverage;

(i) Specified disease or illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance offered as an independent, noncoordinated benefit;

(j) Employer-sponsored self-funded health plans;

(k) Dental only and vision only coverage; and

(l) Plans deemed by the insurance commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner.

((~~(20)~~)) (18) "Material modification" means a change in the actuarial value of the health plan as modified of more than five percent but less than fifteen percent.

((~~(21)~~)) (19) "Preexisting condition" means any medical condition, illness, or injury that existed any time prior to the effective date of coverage.

((~~(22)~~)) (20) "Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan. Any assessment or any "membership," "policy," "contract," "service," or similar fee or charge made by a health carrier in consideration for a health plan is deemed part of the premium. "Premium" shall not include amounts paid as enrollee point-of-service cost-sharing.

((~~(23)~~)) (21) "Review organization" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, health care service contractor as defined in RCW 48.44.010, or health maintenance organization as defined in RCW 48.46.020, and entities affiliated with, under contract with, or acting on behalf of a health carrier to perform a utilization review.

((~~(24)~~)) (22) "Small employer" or "small group" means any person, firm, corporation, partnership, association, political subdivision, sole proprietor, or self-employed individual that is actively engaged in business that employed an average of at least one but no more than fifty employees, during the previous calendar year and employed at least one employee on the first day of the plan year, is not formed primarily for purposes of buying health insurance, and in which a bona

fide employer-employee relationship exists. In determining the number of employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered an employer. Subsequent to the issuance of a health plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, a small employer shall continue to be considered a small employer until the plan anniversary following the date the small employer no longer meets the requirements of this definition. A self-employed individual or sole proprietor who is covered as a group of one must also: (a) Have been employed by the same small employer or small group for at least twelve months prior to application for small group coverage, and (b) verify that he or she derived at least seventy-five percent of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, schedule C or F, for the previous taxable year, except a self-employed individual or sole proprietor in an agricultural trade or business, must have derived at least fifty-one percent of his or her income from the trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, for the previous taxable year.

((~~(25)~~)) (23) "Utilization review" means the prospective, concurrent, or retrospective assessment of the necessity and appropriateness of the allocation of health care resources and services of a provider or facility, given or proposed to be given to an enrollee or group of enrollees.

((~~(26)~~)) (24) "Wellness activity" means an explicit program of an activity consistent with department of health guidelines, such as, smoking cessation, injury and accident prevention, reduction of alcohol misuse, appropriate weight reduction, exercise, automobile and motorcycle safety, blood cholesterol reduction, and nutrition education for the purpose of improving enrollee health status and reducing health service costs.

Sec. 4. RCW 48.43.045 and 2007 c 253 s 12 are each amended to read as follows:

((~~(1)~~)) Every health plan delivered, issued for delivery, or renewed by a health carrier on and after January 1, 1996, shall((~~:~~

~~(a) Permit every category of health care provider to provide health services or care for conditions included in the basic health plan services to the extent that:~~

~~(i) The provision of such health services or care is within the health care providers' permitted scope of practice; and~~

~~(ii) The providers agree to abide by standards related to:~~

~~(A) Provision, utilization review, and cost containment of health services;~~

~~(B) Management and administrative procedures; and~~

~~(C) Provision of cost-effective and clinically efficacious health services.~~

~~(b)~~)) annually report the names and addresses of all officers, directors, or trustees of the health carrier during the preceding year, and the amount of wages, expense reimbursements, or other payments to such individuals, unless substantially similar information is filed with the commissioner or the national association of insurance commissioners. This requirement does not apply to a foreign or alien insurer regulated under chapter 48.20 or 48.21 RCW that files a supplemental compensation exhibit in its annual statement as required by law.

((~~(2) The requirements of subsection (1)(a) of this section do not apply to a licensed health care profession regulated under Title 18 RCW when the licensing statute for the profession states that such requirements do not apply.~~))

NEW SECTION. **Sec. 5.** The following acts or parts of acts are each repealed:

(1) RCW 48.02.062 (Mental health services--Rules) and 2005 c 6 s 10;

(2) RCW 48.20.385 (When injury caused by intoxication or use of narcotics) and 2004 c 112 s 2;

(3) RCW 48.20.390 (Podiatric medicine and surgery) and 1963 c 87 s 1;

(4) RCW 48.20.391 (Diabetes coverage) and 1997 c 276 s 2;

(5) RCW 48.20.392 (Prostate cancer screening) and 2006 c 367 s 2;

(6) RCW 48.20.393 (Mammograms--Insurance coverage) and 1994 sp.s. c 9 s 728 & 1989 c 338 s 1;

(7) RCW 48.20.395 (Reconstructive breast surgery) and 1985 c 54 s 5 & 1983 c 113 s 1;

(8) RCW 48.20.397 (Mastectomy, lumpectomy) and 1985 c 54 s 1;

(9) RCW 48.20.410 (Optometry) and 1965 c 149 s 2;

(10) RCW 48.20.411 (Registered nurses or advanced registered nurses) and 1994 sp.s. c 9 s 729 & 1973 1st ex.s. c 188 s 3;

(11) RCW 48.20.414 (Psychological services) and 1971 ex.s. c 197 s 1;

(12) RCW 48.20.416 (Dentistry) and 1974 ex.s. c 42 s 1;

(13) RCW 48.20.418 (Denturist services) and 1995 c 1 s 21;

(14) RCW 48.20.420 (Dependent child coverage--Continuation for incapacity) and 1985 c 264 s 10 & 1969 ex.s. c 128 s 3;

(15) RCW 48.20.430 (Dependent child coverage--From moment of birth--Congenital anomalies--Notification of birth) and 1983 1st ex.s. c 32 s 18 & 1974 ex.s. c 139 s 1;

(16) RCW 48.20.490 (Continuation of coverage by former spouse and dependents) and 1980 c 10 s 1;

(17) RCW 48.20.520 (Phenylketonuria) and 1988 c 173 s 1;

(18) RCW 48.20.580 (Mental health services--Definition--Coverage required, when) and 2007 c 8 s 1;

(19) RCW 48.21.125 (When injury caused by intoxication or use of narcotics) and 2004 c 112 s 3;

(20) RCW 48.21.130 (Podiatric medicine and surgery) and 1963 c 87 s 2;

(21) RCW 48.21.140 (Optometry) and 1965 c 149 s 3;

(22) RCW 48.21.141 (Registered nurses or advanced registered nurses) and 1994 sp.s. c 9 s 730 & 1973 1st ex.s. c 188 s 4;

(23) RCW 48.21.143 (Diabetes coverage--Definitions) and 2004 c 244 s 10 & 1997 c 276 s 3;

(24) RCW 48.21.144 (Psychological services) and 1971 ex.s. c 197 s 2;

(25) RCW 48.21.146 (Dentistry) and 1974 ex.s. c 42 s 2;

(26) RCW 48.21.148 (Denturist services) and 1995 c 1 s 22;

(27) RCW 48.21.150 (Dependent child coverage--Continuation for incapacity) and 1977 ex.s. c 80 s 32 & 1969 ex.s. c 128 s 4;

(28) RCW 48.21.155 (Dependent child coverage--From moment of birth--Congenital anomalies--Notification of birth) and 1983 1st ex.s. c 32 s 20 & 1974 ex.s. c 139 s 2;

(29) RCW 48.21.160 (Chemical dependency benefits--Legislative declaration) and 1987 c 458 s 13 & 1974 ex.s. c 119 s 1;

(30) RCW 48.21.180 (Chemical dependency benefits--Contracts issued or renewed after January 1, 1988) and 2003 c 248 s 9, 1990 1st ex.s. c 3 s 7, 1987 c 458 s 14, & 1974 ex.s. c 119 s 3;

(31) RCW 48.21.190 (Chemical dependency benefits--RCW 48.21.160 through 48.21.190, 48.44.240 inapplicable, when) and 1975 1st ex.s. c 266 s 10 & 1974 ex.s. c 119 s 5;

(32) RCW 48.21.195 ("Chemical dependency" defined) and 1987 c 458 s 15;

(33) RCW 48.21.197 (Chemical dependency benefits--Rules) and 1987 c 458 s 21;

(34) RCW 48.21.200 (Individual or group disability, health care service contract, health maintenance agreement--Reduction of benefits on basis of other existing coverages) and 2007 c 80 s 3, 1993 c 492 s 282. Prior: 1983 c 202 s 16, 1983 c 106 s 24, & 1975 1st ex.s. c 266 s 20;

(35) RCW 48.21.220 (Home health care, hospice care, optional coverage required--Standards, limitations, restrictions--Rules--Medicare supplemental contracts excluded) and 1988 c 245 s 31, 1984 c 22 s 1, & 1983 c 249 s 1;

(36) RCW 48.21.225 (Mammograms--Insurance coverage) and 1994 sp.s. c 9 s 731 & 1989 c 338 s 2;

(37) RCW 48.21.227 (Prostate cancer screening) and 2006 c 367 s 3;

(38) RCW 48.21.230 (Reconstructive breast surgery) and 1985 c 54 s 6 & 1983 c 113 s 2;

(39) RCW 48.21.235 (Mastectomy, lumpectomy) and 1985 c 54 s 2;

(40) RCW 48.21.241 (Mental health services--Group health plans--Definition--Coverage required, when) and 2007 c 8 s 2, 2006 c 74 s 1, & 2005 c 6 s 3;

(41) RCW 48.21.250 (Continuation option to be offered) and 1984 c 190 s 2;

(42) RCW 48.21.260 (Conversion policy to be offered--Exceptions, conditions) and 2010 c 110 s 1 & 1984 c 190 s 3;

(43) RCW 48.21.270 (Conversion policy--Restrictions and requirements) and 1984 c 190 s 4;

(44) RCW 48.21.280 (Coverage for adopted children) and 1986 c 140 s 3;

(45) RCW 48.21.300 (Phenylketonuria) and 1988 c 173 s 2;

(46) RCW 48.21.310 (Neurodevelopmental therapies--Employer-sponsored group contracts) and 1989 c 345 s 2;

(47) RCW 48.21.320 (Temporomandibular joint disorders--Insurance coverage) and 1989 c 331 s 2;

(48) RCW 48.21A.090 (Home health care, hospice care, optional coverage required--Standards, limitations, restrictions--Rules--Medicare supplemental contracts excluded) and 1989 1st ex.s. c 9 s 220, 1988 c 245 s 32, 1984 c 22 s 2, & 1983 c 249 s 2;

(49) RCW 48.42.100 (Women's health care services--Duties of health care carriers) and 2000 c 7 s 1 & 1995 c 389 s 1;

(50) RCW 48.43.017 (Organ transplant benefit waiting periods--Prior creditable coverage) and 2009 c 82 s 2;

(51) RCW 48.43.041 (Individual health benefit plans--Mandatory benefits) and 2000 c 79 s 26;

(52) RCW 48.43.043 (Colorectal cancer examinations and laboratory tests--Required benefits or coverage) and 2007 c 23 s 1;

(53) RCW 48.43.093 (Health carrier coverage of emergency medical services--Requirements--Conditions) and 1997 c 231 s 301;

(54) RCW 48.43.115 (Maternity services--Intent--Definitions--Patient preference--Clinical sovereignty of provider--Notice to policyholders--Application) and 2003 c 248 s 14 & 1996 c 281 s 1;

(55) RCW 48.43.125 (Coverage at a long-term care facility following hospitalization--Definition) and 1999 c 312 s 2;

(56) RCW 48.43.180 (Denturist services) and 1995 c 1 s 23;

(57) RCW 48.43.185 (General anesthesia services for dental procedures) and 2001 c 321 s 2;

(58) RCW 48.43.190 (Payment of chiropractic services--Parity) and 2008 c 304 s 1;

(59) RCW 48.44.212 (Coverage of dependent children to include newborn infants and congenital anomalies from moment of birth--Notification period) and 1984 c 4 s 1, 1983 c 202 s 5, & 1974 ex.s. c 139 s 3;

(60) RCW 48.44.225 (Podiatric physicians and surgeons not excluded) and 1983 c 154 s 5;

(61) RCW 48.44.240 (Chemical dependency benefits--Provisions of group contracts delivered or renewed after January 1, 1988) and 2005 c 223 s 25, 1990 1st ex.s. c 3 s 12, 1987 c 458 s 16, 1975 1st ex.s. c 266 s 14, & 1974 ex.s. c 119 s 4;

(62) RCW 48.44.245 ("Chemical dependency" defined) and 1987 c 458 s 17;

(63) RCW 48.44.290 (Registered nurses or advanced registered nurses) and 1994 sp.s. c 9 s 733, 1986 c 223 s 6, & 1981 c 175 s 1;

(64) RCW 48.44.300 (Podiatric medicine and surgery--Benefits not to be denied) and 1986 c 223 s 7 & 1983 c 154 s 2;

(65) RCW 48.44.305 (When injury caused by intoxication or use of narcotics) and 2004 c 112 s 4;

(66) RCW 48.44.315 (Diabetes coverage--Definitions) and 2004 c 244 s 12 & 1997 c 276 s 4;

(67) RCW 48.44.320 (Home health care, hospice care, optional coverage required--Standards, limitations, restrictions--Rules--Medicare supplemental contracts excluded) and 1989 1st ex.s. c 9 s 222, 1988 c 245 s 33, 1984 c 22 s 3, & 1983 c 249 s 3;

(68) RCW 48.44.325 (Mammograms--Insurance coverage) and 1994 sp.s. c 9 s 734 & 1989 c 338 s 3;

(69) RCW 48.44.327 (Prostate cancer screening) and 2006 c 367 s 4;

(70) RCW 48.44.330 (Reconstructive breast surgery) and 1985 c 54 s 7 & 1983 c 113 s 3;

(71) RCW 48.44.335 (Mastectomy, lumpectomy) and 1985 c 54 s 3;

(72) RCW 48.44.341 (Mental health services--Health plans--Definition--Coverage required, when) and 2007 c 8 s 3, 2006 c 74 s 2, & 2005 c 6 s 4;

(73) RCW 48.44.344 (Benefits for prenatal diagnosis of congenital disorders--Contracts entered into or renewed on or after January 1, 1990) and 1988 c 276 s 7;

(74) RCW 48.44.360 (Continuation option to be offered) and 1984 c 190 s 5;

(75) RCW 48.44.370 (Conversion contract to be offered--Exceptions, conditions) and 2010 c 110 s 2 & 1984 c 190 s 6;

(76) RCW 48.44.380 (Conversion contract--Restrictions and requirements) and 1984 c 190 s 7;

(77) RCW 48.44.400 (Continuance provisions for former family members) and 1986 c 223 s 11;

(78) RCW 48.44.420 (Coverage for adopted children) and 1986 c 140 s 4;

(79) RCW 48.44.440 (Phenylketonuria) and 1988 c 173 s 3;

(80) RCW 48.44.460 (Temporomandibular joint disorders--Insurance coverage) and 1989 c 331 s 3;

(81) RCW 48.44.500 (Denturist services) and 1995 c 1 s 24;

(82) RCW 48.46.250 (Coverage of dependent children--Newborn infants, congenital anomalies--Notification period) and 1984 c 4 s 2 & 1983 c 202 s 12;

(83) RCW 48.46.272 (Diabetes coverage--Definitions) and 2004 c 244 s 14 & 1997 c 276 s 5;

(84) RCW 48.46.275 (Mammograms--Insurance coverage) and 1994 sp.s. c 9 s 735 & 1989 c 338 s 4;

(85) RCW 48.46.277 (Prostate cancer screening) and 2006 c 367 s 5;

(86) RCW 48.46.280 (Reconstructive breast surgery) and 1985 c 54 s 8 & 1983 c 113 s 4;

(87) RCW 48.46.285 (Mastectomy, lumpectomy) and 1985 c 54 s 4;

(88) RCW 48.46.291 (Mental health services--Health plans--Definition--Coverage required, when) and 2007 c 8 s 4, 2006 c 74 s 3, & 2005 c 6 s 5;

(89) RCW 48.46.350 (Chemical dependency treatment) and 2003 c 248 s 19, 1990 1st ex.s. c 3 s 14, 1987 c 458 s 18, & 1983 c 106 s 13;

(90) RCW 48.46.355 ("Chemical dependency" defined) and 1987 c 458 s 19;

(91) RCW 48.46.375 (Benefits for prenatal diagnosis of congenital disorders--Agreements entered into or renewed on or after January 1, 1990) and 1988 c 276 s 8;

(92) RCW 48.46.440 (Continuation option to be offered) and 1984 c 190 s 8;

(93) RCW 48.46.450 (Conversion agreement to be offered--Exceptions, conditions) and 2010 c 110 s 3 & 1984 c 190 s 9;

(94) RCW 48.46.460 (Conversion agreement--Restrictions and requirements) and 1984 c 190 s 10;

(95) RCW 48.46.480 (Continuation of coverage of former family members) and 1985 c 320 s 8;

(96) RCW 48.46.490 (Coverage for adopted children) and 1986 c 140 s 5;

(97) RCW 48.46.510 (Phenylketonuria) and 1988 c 173 s 4;

(98) RCW 48.46.520 (Neurodevelopmental therapies--Employer-sponsored group contracts) and 1989 c 345 s 3;

(99) RCW 48.46.530 (Temporomandibular joint disorders--Insurance coverage) and 1989 c 331 s 4;

(100) RCW 48.46.570 (Denturist services) and 1995 c 1 s 25;

(101) RCW 48.46.580 (When injury caused by intoxication or use of narcotics) and 2004 c 112 s 5;

(102) RCW 48.125.200 (Prostate cancer screening) and 2006 c 367 s 6; and

(103) RCW 48.43.515 (Access to appropriate health services--Enrollee options--Rules) and 2000 c 5 s 7.

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