WEST VIRGINIA LEGISLATURE

2018 REGULAR SESSION

Introduced

Senate Bill 478

FISCAL NOTE

By Senators Stollings, Palumbo, Jeffries, and Plymale

[Introduced February 5, 2018; Referred to the Committee on Banking and Insurance; and then to the Committee on Finance]

1 A BILL to amend and reenact §5-16-7 and §5-16-9 of the Code of West Virginia, 1931, as
2 amended; to amend said code by adding thereto a new section, designated §5-16B-6f; to
3 amend said code by adding thereto a new section, designated §9-5-27; to amend said
4 code by adding thereto a new section, designated §33-15-4p; to amend said code by
5 adding thereto a new section, designated §33-16-3bb; to amend said code by adding
6 thereto a new section, designated §33-24-7q; to amend said code by adding thereto a
7 new section, designated §33-25-8n; and to amend said code by adding thereto a new
8 section, designated §33-25A-8p, all relating to mandatory insurance coverage for
9 treatment of mitochondrial disease and other similar metabolism or genetic conditions,
10 including, but not limited to, the use of certain vitamin and nutritional supplements; and
11 requiring coverage even if supplements must be compounded.

Be it enacted by the Legislature of West Virginia:

CHAPTER 5. GENERAL POWERS AND AUTHORITY OF THE GOVERNOR, SECRETARY OF STATE, AND ATTORNEY GENERAL; BOARD OF PUBLIC WORKS; MISCELLANEOUS AGENCIES, COMMISSIONS, OFFICES, PROGRAMS, ETC.

ARTICLE 16. WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE ACT.

§5-16-7. Authorization to establish group hospital and surgical insurance plan, group major medical insurance plan, group prescription drug plan, and group life and accidental death insurance plan; rules for administration of plans; mandated benefits; what plans may provide; optional plans; separate rating for claims experience purposes.

1 (a) The agency shall establish a group hospital and surgical insurance plan or plans, a
2 group prescription drug insurance plan or plans, a group major medical insurance plan or plans,

3 and a group life and accidental death insurance plan or plans for those employees herein made
4 eligible and establish and promulgate rules for the administration of these plans subject to the
5 limitations contained in this article. These plans shall include:
6 (1) Coverages and benefits for x-ray and laboratory services in connection with
7 mammograms when medically appropriate and consistent with current guidelines from the United
8 States Preventive Services Task Force; pap smears, either conventional or liquid-based cytology,
9 whichever is medically appropriate and consistent with the current guidelines from either the
10 United States Preventive Services Task Force or The American College of Obstetricians and
11 Gynecologists; and a test for the human papilloma virus (HPV) when medically appropriate and
12 consistent with current guidelines from either the United States Preventive Services Task Force
13 or The American College of Obstetricians and Gynecologists, when performed for cancer
14 screening or diagnostic services on a woman age 18 or over;
15 (2) Annual checkups for prostate cancer in men age 50 and over;
16 (3) Annual screening for kidney disease as determined to be medically necessary by a
17 physician using any combination of blood pressure testing, urine albumin or urine protein testing,
18 and serum creatinine testing as recommended by the National Kidney Foundation;
19 (4) For plans that include maternity benefits, coverage for inpatient care in a duly licensed
20 healthcare facility for a mother and her newly born infant for the length of time which the attending
21 physician considers medically necessary for the mother or her newly born child. No plan may
22 deny payment for a mother or her newborn child prior to 48 hours following a vaginal delivery or
23 prior to 96 hours following a caesarean section delivery if the attending physician considers
24 discharge medically inappropriate;
25 (5) For plans which provide coverages for post-delivery care to a mother and her newly
26 born child in the home, coverage for inpatient care following childbirth as provided in subdivision
27 (4) of this subsection if inpatient care is determined to be medically necessary by the attending
28 physician. These plans may include, among other things, medicines, medical equipment,

29 prosthetic appliances, and any other inpatient and outpatient services and expenses considered
30 appropriate and desirable by the agency; and

31 (6) Coverage for treatment of serious mental illness:

32 (A) The coverage does not include custodial care, residential care, or schooling. For
33 purposes of this section, “serious mental illness” means an illness included in the American
34 Psychiatric Association’s diagnostic and statistical manual of mental disorders, as periodically
35 revised, under the diagnostic categories or subclassifications of: (i) Schizophrenia and other
36 psychotic disorders; (ii) bipolar disorders; (iii) depressive disorders; (iv) substance-related
37 disorders with the exception of caffeine-related disorders and nicotine-related disorders; (v)
38 anxiety disorders; and (vi) anorexia and bulimia. With regard to a covered individual who has not
39 yet attained the age of 19 years, “serious mental illness” also includes attention deficit
40 hyperactivity disorder, separation anxiety disorder, and conduct disorder.

41 (B) Notwithstanding any other provision in this section to the contrary, if the agency
42 demonstrates that its total costs for the treatment of mental illness for any plan exceeds two
43 percent of the total costs for such plan in any experience period, then the agency may apply
44 whatever additional cost-containment measures may be necessary in order to maintain costs
45 below two percent of the total costs for the plan for the next experience period. These measures
46 may include, but are not limited to, limitations on inpatient and outpatient benefits.

47 (C) The agency shall not discriminate between medical-surgical benefits and mental
48 health benefits in the administration of its plan. With regard to both medical-surgical and mental
49 health benefits, it may make determinations of medical necessity and appropriateness and it may
50 use recognized healthcare quality and cost management tools including, but not limited to,
51 limitations on inpatient and outpatient benefits, utilization review, implementation of cost-
52 containment measures, preauthorization for certain treatments, setting coverage levels, setting
53 maximum number of visits within certain time periods, using capitated benefit arrangements,
54 using fee-for-service arrangements, using third-party administrators, using provider networks, and

55 using patient cost sharing in the form of copayments, deductibles, and coinsurance.

56 (7) Coverage for general anesthesia for dental procedures and associated outpatient
57 hospital or ambulatory facility charges provided by appropriately licensed healthcare individuals
58 in conjunction with dental care if the covered person is:

59 (A) Seven years of age or younger or is developmentally disabled and is an individual for
60 whom a successful result cannot be expected from dental care provided under local anesthesia
61 because of a physical, intellectual, or other medically compromising condition of the individual
62 and for whom a superior result can be expected from dental care provided under general
63 anesthesia.

64 (B) A child who is 12 years of age or younger with documented phobias or with
65 documented mental illness and with dental needs of such magnitude that treatment should not be
66 delayed or deferred and for whom lack of treatment can be expected to result in infection, loss of
67 teeth, or other increased oral or dental morbidity and for whom a successful result cannot be
68 expected from dental care provided under local anesthesia because of such condition and for
69 whom a superior result can be expected from dental care provided under general anesthesia.

70 (8) (A) Any plan issued or renewed on or after January 1, 2012, shall include coverage for
71 diagnosis, evaluation, and treatment of autism spectrum disorder in individuals ages 18 months
72 to 18 years. To be eligible for coverage and benefits under this subdivision, the individual must
73 be diagnosed with autism spectrum disorder at age eight or younger. Such plan shall provide
74 coverage for treatments that are medically necessary and ordered or prescribed by a licensed
75 physician or licensed psychologist and in accordance with a treatment plan developed from a
76 comprehensive evaluation by a certified behavior analyst for an individual diagnosed with autism
77 spectrum disorder.

78 (B) The coverage shall include, but not be limited to, applied behavior analysis which shall
79 be provided or supervised by a certified behavior analyst. The annual maximum benefit for applied
80 behavior analysis required by this subdivision shall be in an amount not to exceed $30,000 per

81 individual for three consecutive years from the date treatment commences. At the conclusion of
82 the third year, coverage for applied behavior analysis required by this subdivision shall be in an
83 amount not to exceed $2,000 per month, until the individual reaches 18 years of age, as long as
84 the treatment is medically necessary and in accordance with a treatment plan developed by a
85 certified behavior analyst pursuant to a comprehensive evaluation or reevaluation of the
86 individual. This subdivision does not limit, replace or affect any obligation to provide services to
87 an individual under the Individuals with Disabilities Education Act, 20 U. S. C. §1400 *et seq*., as
88 amended from time to time or other publicly funded programs. Nothing in this subdivision requires
89 reimbursement for services provided by public school personnel.

90 (C) The certified behavior analyst shall file progress reports with the agency semiannually.
91 In order for treatment to continue, the agency must receive objective evidence or a clinically
92 supportable statement of expectation that:

93 (i) The individual's condition is improving in response to treatment;

94 (ii) A maximum improvement is yet to be attained; and

95 (iii) There is an expectation that the anticipated improvement is attainable in a reasonable
96 and generally predictable period of time.

97 (D) On or before January 1 each year, the agency shall file an annual report with the Joint
98 Committee on Government and Finance describing its implementation of the coverage provided
99 pursuant to this subdivision. The report shall include, but not be limited to, the number of
100 individuals in the plan utilizing the coverage required by this subdivision, the fiscal and
101 administrative impact of the implementation and any recommendations the agency may have as
102 to changes in law or policy related to the coverage provided under this subdivision. In addition,
103 the agency shall provide such other information as required by the Joint Committee on
104 Government and Finance as it may request.

105 (E) For purposes of this subdivision, the term:

106 (i) "Applied behavior analysis" means the design, implementation and evaluation of

107 environmental modifications using behavioral stimuli and consequences in order to produce
108 socially significant improvement in human behavior and includes the use of direct observation,
109 measurement, and functional analysis of the relationship between environment and behavior.
110 (ii) “Autism spectrum disorder” means any pervasive developmental disorder including
111 autistic disorder, Asperger’s Syndrome, Rett Syndrome, childhood disintegrative disorder, or
112 Pervasive Development Disorder as defined in the most recent edition of the Diagnostic and
113 Statistical Manual of Mental Disorders of the American Psychiatric Association.
114 (iii) “Certified behavior analyst” means an individual who is certified by the Behavior
115 Analyst Certification Board or certified by a similar nationally recognized organization.
116 (iv) “Objective evidence” means standardized patient assessment instruments, outcome
117 measurements tools, or measurable assessments of functional outcome. Use of objective
118 measures at the beginning of treatment, during, and after treatment is recommended to quantify
119 progress and support justifications for continued treatment. The tools are not required but their
120 use will enhance the justification for continued treatment.
121 (F) To the extent that the application of this subdivision for autism spectrum disorder
122 causes an increase of at least one percent of actual total costs of coverage for the plan year, the
123 agency may apply additional cost containment measures.
124 (G) To the extent that the provisions of this subdivision require benefits that exceed the
125 essential health benefits specified under section 1302(b) of the Patient Protection and Affordable
126 Care Act, Pub. L. No. 111-148, as amended, the specific benefits that exceed the specified
127 essential health benefits shall not be required of insurance plans offered by the Public Employees
128 Insurance Agency.
129 (9) For plans that include maternity benefits, coverage for the same maternity benefits for
130 all individuals participating in or receiving coverage under plans that are issued or renewed on or
131 after January 1, 2014: *Provided,* That to the extent that the provisions of this subdivision require
132 benefits that exceed the essential health benefits specified under section 1302(b) of the Patient

133 Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, the specific benefits that
134 exceed the specified essential health benefits shall not be required of a health benefit plan when
135 the plan is offered in this state.

136 (10) A policy, plan, or contract that is issued or renewed on or after January 1, 2019, and
137 that is subject to this section, shall provide coverage for treatment of mitochondrial disease and
138 other similar metabolism or genetic conditions, including, but not limited to, through the use of
139 vitamin and nutritional supplements, such as CoEnzyme Q10, Vitamin E, Vitamin B1, Vitamin B2,
140 Vitamin K1, and L-Carnitine, and other products recommended for treatment under the direction
141 of a physician. Coverage under this subdivision shall not be denied because two or more
142 supplements are compounded.

143 (b) The agency shall, with full authorization, make available to each eligible employee, at
144 full cost to the employee, the opportunity to purchase optional group life and accidental death
145 insurance as established under the rules of the agency. In addition, each employee is entitled to
146 have his or her spouse and dependents, as defined by the rules of the agency, included in the
147 optional coverage, at full cost to the employee, for each eligible dependent.

148 (c) The finance board may cause to be separately rated for claims experience purposes:

149 (1) All employees of the State of West Virginia;

150 (2) All teaching and professional employees of state public institutions of higher education
151 and county boards of education;

152 (3) All nonteaching employees of the Higher Education Policy Commission, West Virginia
153 Council for Community and Technical College Education and county boards of education; or

154 (4) Any other categorization which would ensure the stability of the overall program.

155 (d) The agency shall maintain the medical and prescription drug coverage for Medicare-
156 eligible retirees by providing coverage through one of the existing plans or by enrolling the
157 Medicare-eligible retired employees into a Medicare-specific plan, including, but not limited to, the
158 Medicare/Advantage Prescription Drug Plan. If a Medicare-specific plan is no longer available or

159 advantageous for the agency and the retirees, the retirees remain eligible for coverage through
160 the agency.

§5-16-9. Authorization to execute contracts for group hospital and surgical insurance, group major medical insurance, group prescription drug insurance, group life and accidental death insurance, and other accidental death insurance; mandated benefits; limitations; awarding of contracts; reinsurance; certificates for covered employees; discontinuance of contracts.

1 (a) The director is hereby given exclusive authorization to execute such contract or
2 contracts as are necessary to carry out the provisions of this article and to provide the plan or
3 plans of group hospital and surgical insurance coverage, group major medical insurance
4 coverage, group prescription drug insurance coverage, and group life and accidental death
5 insurance coverage selected in accordance with the provisions of this article, such contract or
6 contracts to be executed with one or more agencies, corporations, insurance companies or
7 service organizations licensed to sell group hospital and surgical insurance, group major medical
8 insurance, group prescription drug insurance and group life and accidental death insurance in this
9 state.

10 (b) The group hospital or surgical insurance coverage and group major medical insurance
11 coverage herein provided shall include coverages and benefits for x-ray and laboratory services
12 in connection with mammogram and pap smears when performed for cancer screening or
13 diagnostic services and annual checkups for prostate cancer in men age 50 and over. Such
14 benefits shall include, but not be limited to, the following:

15 (1) Mammograms when medically appropriate and consistent with the current guidelines
16 from the United States Preventive Services Task Force;

17 (2) A pap smear, either conventional or liquid-based cytology, whichever is medically
18 appropriate and consistent with the current guidelines from the United States Preventive Services
19 Task Force or The American College of Obstetricians and Gynecologists, for women age 18 and

over;

(3) A test for the human papilloma virus (HPV) for women age 18 or over, when medically appropriate and consistent with the current guidelines from either the United States Preventive Services Task Force or The American College of Obstetricians and Gynecologists for women age 18 and over;

(4) A checkup for prostate cancer annually for men age 50 or over; and

(5) Annual screening for kidney disease as determined to be medically necessary by a physician using any combination of blood pressure testing, urine albumin or urine protein testing, and serum creatinine testing as recommended by the National Kidney Foundation.

(6) Coverage for general anesthesia for dental procedures and associated outpatient hospital or ambulatory facility charges provided by appropriately licensed healthcare individuals in conjunction with dental care if the covered person is:

(A) Seven years of age or younger or is developmentally disabled and is either an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition of the individual and for whom a superior result can be expected from dental care provided under general anesthesia; or

(B) A child who is 12 years of age or younger with documented phobias, or with documented mental illness, and with dental needs of such magnitude that treatment should not be delayed or deferred and for whom lack of treatment can be expected to result in infection, loss of teeth or other increased oral or dental morbidity and for whom a successful result cannot be expected from dental care provided under local anesthesia because of such condition and for whom a superior result can be expected from dental care provided under general anesthesia.

(7) A policy, plan, or contract that is issued or renewed on or after January 1, 2019, and that is subject to this section, shall provide coverage for treatment of mitochondrial disease and other similar metabolism or genetic conditions, including, but not limited to, through the use of

46 vitamin and nutritional supplements, such as CoEnzyme Q10, Vitamin E, Vitamin B1, Vitamin B2,
47 Vitamin K1, and L-Carnitine, and other products recommended for treatment under the direction
48 of a physician. Coverage under this subdivision shall not be denied because two or more
49 supplements are compounded.

50 (c) The group life and accidental death insurance herein provided shall be in the amount
51 of $10,000 for every employee. The amount of the group life and accidental death insurance to
52 which an employee would otherwise be entitled shall be reduced to $5,000 upon such employee
53 attaining age 65.

54 (d) All of the insurance coverage to be provided for under this article may be included in
55 one or more similar contracts issued by the same or different carriers.

56 (e) The provisions of §5A-3-1 *et seq.* of this code, relating to the Division of Purchasing of
57 the Department of Finance and Administration, shall not apply to any contracts for any insurance
58 coverage or professional services authorized to be executed under the provisions of this article.
59 Before entering into any contract for any insurance coverage, as authorized in this article, the
60 director shall invite competent bids from all qualified and licensed insurance companies or
61 carriers, who may wish to offer plans for the insurance coverage desired: *Provided,* That the
62 director shall negotiate and contract directly with healthcare providers and other entities,
63 organizations and vendors in order to secure competitive premiums, prices and other financial
64 advantages. The director shall deal directly with insurers or healthcare providers and other
65 entities, organizations and vendors in presenting specifications and receiving quotations for bid
66 purposes. No commission or finder's fee, or any combination thereof, shall be paid to any
67 individual or agent; but this shall not preclude an underwriting insurance company or companies,
68 at their own expense, from appointing a licensed resident agent, within this state, to service the
69 companies' contracts awarded under the provisions of this article. Commissions reasonably
70 related to actual service rendered for the agent or agents may be paid by the underwriting
71 company or companies: *Provided, however,* That in no event shall payment be made to any agent

72 or agents when no actual services are rendered or performed. The director shall award the
73 contract or contracts on a competitive basis. In awarding the contract or contracts the director
74 shall take into account the experience of the offering agency, corporation, insurance company, or
75 service organization in the group hospital and surgical insurance field, group major medical
76 insurance field, group prescription drug field, and group life and accidental death insurance field,
77 and its facilities for the handling of claims. In evaluating these factors, the director may employ
78 the services of impartial, professional insurance analysts or actuaries or both. Any contract
79 executed by the director with a selected carrier shall be a contract to govern all eligible employees
80 subject to the provisions of this article. Nothing contained in this article shall prohibit any insurance
81 carrier from soliciting employees covered hereunder to purchase additional hospital and surgical,
82 major medical or life and accidental death insurance coverage.

83 (f) The director may authorize the carrier with whom a primary contract is executed to
84 reinsure portions of the contract with other carriers which elect to be a reinsurer and who are
85 legally qualified to enter into a reinsurance agreement under the laws of this state.

86 (g) Each employee who is covered under any contract or contracts shall receive a
87 statement of benefits to which the employee, his or her spouse and his or her dependents are
88 entitled under the contract, setting forth the information as to whom the benefits are payable, to
89 whom claims shall be submitted and a summary of the provisions of the contract or contracts as
90 they affect the employee, his or her spouse and his or her dependents.

91 (h) The director may at the end of any contract period discontinue any contract or contracts
92 it has executed with any carrier and replace the same with a contract or contracts with any other
93 carrier or carriers meeting the requirements of this article.

94 (i) The director shall provide by contract or contracts entered into under the provisions of
95 this article the cost for coverage of children's immunization services from birth through age 16
96 years to provide immunization against the following illnesses: Diphtheria, polio, mumps, measles,
97 rubella, tetanus, hepatitis-b, haemophilus influenzae-b, and whooping cough. Additional

98 immunizations may be required by the Commissioner of the Bureau for Public Health for public
99 health purposes. Any contract entered into to cover these services shall require that all costs
100 associated with immunization, including the cost of the vaccine, if incurred by the healthcare
101 provider, and all costs of vaccine administration be exempt from any deductible, per visit charge
102 and/or copayment provisions which may be in force in these policies or contracts. This section
103 does not require that other healthcare services provided at the time of immunization be exempt
104 from any deductible and/or copayment provisions.

ARTICLE 16B. WEST VIRGINIA CHILDREN'S HEALTH INSURANCE PROGRAM.

§5-16B-6f. Coverage for mitochondrial disease.

1 A policy, plan, or contract that is issued or renewed on or after January 1, 2019, and that
2 is subject to this article shall provide coverage for treatment of mitochondrial disease and other
3 similar metabolism or genetic conditions, including, but not limited to, through the use of vitamin
4 and nutritional supplements, such as CoEnzyme Q10, Vitamin E, Vitamin B1, Vitamin B2, Vitamin
5 K1, and L-Carnitine, and other products recommended for treatment under the direction of a
6 physician. Coverage under this section shall not be denied because two or more supplements are
7 compounded.

CHAPTER 9. HUMAN SERVICES.

ARTICLE 5. MISCELLANEOUS PROVISIONS.

§9-5-27. Coverage for mitochondrial disease.

1 A policy, plan, or contract that is issued or renewed on or after January 1, 2019, and that
2 is subject to this article shall provide coverage for treatment of mitochondrial disease and other
3 similar metabolism or genetic conditions, including, but not limited to, through the use of vitamin
4 and nutritional supplements, such as CoEnzyme Q10, Vitamin E, Vitamin B1, Vitamin B2, Vitamin
5 K1, and L-Carnitine, and other products recommended for treatment under the direction of a
6 physician. Coverage under this section shall not be denied because two or more supplements are

7 compounded.

CHAPTER 33. INSURANCE.

ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.

§33-15-4p. Coverage for mitochondrial disease.

1 A policy, plan, or contract that is issued or renewed on or after January 1, 2019, and that
2 is subject to this article shall provide coverage for treatment of mitochondrial disease and other
3 similar metabolism or genetic conditions, including, but not limited to, through the use of vitamin
4 and nutritional supplements, such as CoEnzyme Q10, Vitamin E, Vitamin B1, Vitamin B2, Vitamin
5 K1, and L-Carnitine, and other products recommended for treatment under the direction of a
6 physician. Coverage under this section shall not be denied because two or more supplements are
7 compounded.

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§33-16-3bb. Coverage for mitochondrial disease.

1 A policy, plan, or contract that is issued or renewed on or after January 1, 2019, and that
2 is subject to this article shall provide coverage for treatment of mitochondrial disease and other
3 similar metabolism or genetic conditions, including, but not limited to, through the use of vitamin
4 and nutritional supplements, such as CoEnzyme Q10, Vitamin E, Vitamin B1, Vitamin B2, Vitamin
5 K1, and L-Carnitine, and other products recommended for treatment under the direction of a
6 physician. Coverage under this section shall not be denied because two or more supplements are
7 compounded.

ARTICLE 24. HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS, DENTAL SERVICE CORPORATIONS, AND HEALTH SERVICE CORPORATIONS.

§33-24-7q. Coverage for mitochondrial disease.

1 A policy, plan, or contract that is issued or renewed on or after January 1, 2019, and that

2 is subject to this article shall provide coverage for treatment of mitochondrial disease and other
3 similar metabolism or genetic conditions, including, but not limited to, through the use of vitamin
4 and nutritional supplements, such as CoEnzyme Q10, Vitamin E, Vitamin B1, Vitamin B2, Vitamin
5 K1, and L-Carnitine, and other products recommended for treatment under the direction of a
6 physician. Coverage under this section shall not be denied because two or more supplements are
7 compounded.

ARTICLE 25. HEALTHCARE CORPORATIONS.

§33-25-8n. Coverage for mitochondrial disease.

1 A policy, plan, or contract that is issued or renewed on or after January 1, 2019, and that
2 is subject to this article shall provide coverage for treatment of mitochondrial disease and other
3 similar metabolism or genetic conditions, including, but not limited to, through the use of vitamin
4 and nutritional supplements, such as CoEnzyme Q10, Vitamin E, Vitamin B1, Vitamin B2, Vitamin
5 K1, and L-Carnitine, and other products recommended for treatment under the direction of a
6 physician. Coverage under this section shall not be denied because two or more supplements are
7 compounded.

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

§33-25A-8p. Coverage for mitochondrial disease.

1 A policy, plan, or contract that is issued or renewed on or after January 1, 2019, and that
2 is subject to this article shall provide coverage for treatment of mitochondrial disease and other
3 similar metabolism or genetic conditions, including. but not limited to, through the use of vitamin
4 and nutritional supplements, such as CoEnzyme Q10, Vitamin E, Vitamin B1, Vitamin B2, Vitamin
5 K1, and L-Carnitine, and other products recommended for treatment under the direction of a
6 physician. Coverage under this section shall not be denied because two or more supplements are
7 compounded.

NOTE: The purpose of this bill is to mandate insurance coverage for treatment of

mitochondrial disease.

Strike-throughs indicate language that would be stricken from a heading or the present law and underscoring indicates new language that would be added.