WEST VIRGINIA LEGISLATURE

2018 REGULAR SESSION

Enrolled

Senate Bill 299

BY SENATORS BOLEY, BOSO, DRENNAN, FACEMIRE,

FERNS, GAUNCH, MARONEY, PALUMBO, PLYMALE,

PREZIOSO, STOLLINGS, AND BLAIR

[Passed March 8, 2018; in effect 90 days from passage]
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[Passed March 8, 2018; in effect 90 days from passage]
AN ACT to amend and reenact §5-16-7 and §5-16-9 of the Code of West Virginia, 1931, as amended; to amend said code by adding thereto a new section, designated §33-15-4p; to amend said code by adding thereto a new section, designated §33-16-3bb; to amend said code by adding thereto a new section, designated §33-24-7q; to amend said code by adding thereto a new section, designated §33-25-8n; and to amend said code by adding thereto a new section, designated §33-25A-8p, all relating to mandatory insurance coverage, up to the age of 20, for certain medical foods for amino acid-based formulas; providing a list of diagnosed conditions for which insurance coverage should extend; providing that coverage extends to medically necessary foods for home use when prescribed by a physician; defining terms; and providing for exclusions from such coverage.

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.

(a) The agency shall establish a group hospital and surgical insurance plan or plans, a group prescription drug insurance plan or plans, a group major medical insurance plan or plans
and a group life and accidental death insurance plan or plans for those employees herein made
eligible and establish and promulgate rules for the administration of these plans subject to the
limitations contained in this article. These plans shall include:

(1) Coverages and benefits for x-ray and laboratory services in connection with
mammograms when medically appropriate and consistent with current guidelines from the United
States Preventive Services Task Force; pap smears, either conventional or liquid-based cytology,
whichever is 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; and a test for the human papilloma virus (HPV) when medically appropriate and
consistent with current guidelines from either the United States Preventive Services Task Force
or the American College of Obstetricians and Gynecologists, when performed for cancer
screening or diagnostic services on a woman age 18 or over;

(2) Annual checkups for prostate cancer in men age 50 and over;

(3) 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;

(4) For plans that include maternity benefits, coverage for inpatient care in a duly licensed
healthcare facility for a mother and her newly born infant for the length of time which the attending
physician considers medically necessary for the mother or her newly born child. No plan may
deny payment for a mother or her newborn child prior to 48 hours following a vaginal delivery or
prior to 96 hours following a caesarean section delivery if the attending physician considers
discharge medically inappropriate;

(5) For plans which provide coverages for post-delivery care to a mother and her newly
born child in the home, coverage for inpatient care following childbirth as provided in §5-16-7(a)(4)
of this code if inpatient care is determined to be medically necessary by the attending physician.

These plans may include, among other things, medicines, medical equipment, prosthetic
appliances, and any other inpatient and outpatient services and expenses considered appropriate
and desirable by the agency; and

(6) Coverage for treatment of serious mental illness:

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

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

(C) The agency shall not discriminate between medical-surgical benefits and mental
health benefits in the administration of its plan. With regard to both medical-surgical and mental
health benefits, it may make determinations of medical necessity and appropriateness and it may
use recognized healthcare quality and cost management tools including, but not limited to,
limitations on inpatient and outpatient benefits, utilization review, implementation of cost-
containment measures, preauthorization for certain treatments, setting coverage levels, setting
maximum number of visits within certain time periods, using capitated benefit arrangements,
using fee-for-service arrangements, using third-party administrators, using provider networks, and
using patient cost sharing in the form of copayments, deductibles, and coinsurance.
(7) 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 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.

(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.

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

(B) The coverage shall include, but not be limited to, applied behavior analysis which shall be provided or supervised by a certified behavior analyst. The annual maximum benefit for applied behavior analysis required by this subdivision shall be in an amount not to exceed $30,000 per individual for three consecutive years from the date treatment commences. At the conclusion of
the third year, coverage for applied behavior analysis required by this subdivision shall be in an amount not to exceed $2,000 per month, until the individual reaches 18 years of age, as long as the treatment is medically necessary and in accordance with a treatment plan developed by a certified behavior analyst pursuant to a comprehensive evaluation or reevaluation of the individual. This subdivision does not limit, replace or affect any obligation to provide services to an individual under the Individuals with Disabilities Education Act, 20 U. S. C. §1400 et seq., as amended from time to time or other publicly funded programs. Nothing in this subdivision requires reimbursement for services provided by public school personnel.

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

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

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

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

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

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

(i) “Applied behavior analysis” means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences in order to produce
socially significant improvement in human behavior and includes the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

(ii) “Autism spectrum disorder” means any pervasive developmental disorder including autistic disorder, Asperger’s Syndrome, Rett Syndrome, childhood disintegrative disorder, or Pervasive Development Disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(iii) “Certified behavior analyst” means an individual who is certified by the Behavior Analyst Certification Board or certified by a similar nationally recognized organization.

(iv) “Objective evidence” means standardized patient assessment instruments, outcome measurements tools, or measurable assessments of functional outcome. Use of objective measures at the beginning of treatment, during, and after treatment is recommended to quantify progress and support justifications for continued treatment. The tools are not required but their use will enhance the justification for continued treatment.

(F) To the extent that the application of this subdivision for autism spectrum disorder causes an increase of at least one percent of actual total costs of coverage for the plan year, the agency may apply additional cost containment measures.

(G) To the extent that the provisions of this subdivision require benefits that exceed the essential health benefits specified under section 1302(b) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, the specific benefits that exceed the specified essential health benefits shall not be required of insurance plans offered by the Public Employees Insurance Agency.

(9) For plans that include maternity benefits, coverage for the same maternity benefits for all individuals participating in or receiving coverage under plans that are issued or renewed on or after January 1, 2014: Provided, That to the extent that the provisions of this subdivision require benefits that exceed the essential health benefits specified under section 1302(b) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, the specific benefits that
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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
137 (10) (A) A policy, plan, or contract that is issued or renewed on or after January 1, 2019,
138 and that is subject to this section, shall provide coverage, through the age of 20, for amino acid-
139 based formula for the treatment of severe protein-allergic conditions or impaired absorption of
140 nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the
141 gastrointestinal tract. This includes the following conditions, if diagnosed as related to the disorder
142 by a physician licensed to practice in this state pursuant to either §30-3-1 et seq. or §30-14-1 et
143 seq. of this code:
144
145 (i) Immunoglobulin E and Nonimmunoglobulin E-medicated allergies to multiple food
146 proteins;
147
148 (ii) Severe food protein-induced enterocolitis syndrome;
149
150 (iii) Eosinophilic disorders as evidenced by the results of a biopsy; and
151
152 (iv) Impaired absorption of nutrients caused by disorders affecting the absorptive surface,
153 function, length, and motility of the gastrointestinal tract (short bowel).
154
155 (B) The coverage required by §5-16-7(a)(10)(A) of this code shall include medical foods
156 for home use for which a physician has issued a prescription and has declared them to be
157 medically necessary, regardless of methodology of delivery.
158
159 (C) For purposes of this subdivision, “medically necessary foods” or “medical foods” shall
160 mean prescription amino acid-based elemental formulas obtained through a pharmacy: Provided,
161 That these foods are specifically designated and manufactured for the treatment of severe allergic
162 conditions or short bowel.
163
164 (D) The provisions of this subdivision shall not apply to persons with an intolerance for
165 lactose or soy.
166
167 (b) The agency shall, with full authorization, make available to each eligible employee, at
168 full cost to the employee, the opportunity to purchase optional group life and accidental death
insurance as established under the rules of the agency. In addition, each employee is entitled to
have his or her spouse and dependents, as defined by the rules of the agency, included in the
optional coverage, at full cost to the employee, for each eligible dependent.

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

(1) All employees of the State of West Virginia;
(2) All teaching and professional employees of state public institutions of higher education
and county boards of education;
(3) All nonteaching employees of the Higher Education Policy Commission, West Virginia
Council for Community and Technical College Education and county boards of education; or
(4) Any other categorization which would ensure the stability of the overall program.

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

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

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

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

(2) A pap smear, either conventional or liquid-based cytology, whichever is medically
appropriate and consistent with the current guidelines from the United States Preventive Services
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) 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, through the age of 20, for amino acid-based formula for the treatment of severe protein-allergic conditions or impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract. This includes the following conditions, if diagnosed as related to the disorder by a physician licensed to practice in this state pursuant to either §30-3-1 et seq. or §30-14-1 et seq. of this code:

(i) Immunoglobulin E and Nonimmunoglobulin E-medicated allergies to multiple food proteins;

(ii) Severe food protein-induced enterocolitis syndrome;

(iii) Eosinophilic disorders as evidenced by the results of a biopsy; and

(iv) Impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract (short bowel).

(B) The coverage required by §15-16-9(b)(7)(A) of this code shall include medical foods for home use for which a physician has issued a prescription and has declared them to be medically necessary, regardless of methodology of delivery.
(C) For purposes of this subdivision, “medically necessary foods” or “medical foods” shall mean prescription amino acid-based elemental formulas obtained through a pharmacy: Provided, That these foods are specifically designated and manufactured for the treatment of severe allergic conditions or short bowel.

(D) The provisions of this subdivision shall not apply to persons with an intolerance for lactose or soy.

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

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

(e) The provisions of §5A-3-1 et seq. of this code, relating to the Division of Purchasing of the Department of Finance and Administration, shall not apply to any contracts for any insurance coverage or professional services authorized to be executed under the provisions of this article. Before entering into any contract for any insurance coverage, as authorized in this article, the director shall invite competent bids from all qualified and licensed insurance companies or carriers, who may wish to offer plans for the insurance coverage desired: Provided, That the director shall negotiate and contract directly with healthcare providers and other entities, organizations and vendors in order to secure competitive premiums, prices, and other financial advantages. The director shall deal directly with insurers or healthcare providers and other entities, organizations, and vendors in presenting specifications and receiving quotations for bid purposes. No commission or finder’s fee, or any combination thereof, shall be paid to any individual or agent; but this shall not preclude an underwriting insurance company or companies, at their own expense, from appointing a licensed resident agent, within this state, to service the companies’ contracts awarded under the provisions of this article. Commissions reasonably
related to actual service rendered for the agent or agents may be paid by the underwriting
company or companies: *Provided, however,* That in no event shall payment be made to any agent
or agents when no actual services are rendered or performed. The director shall award the
contract or contracts on a competitive basis. In awarding the contract or contracts the director
shall take into account the experience of the offering agency, corporation, insurance company, or
service organization in the group hospital and surgical insurance field, group major medical
insurance field, group prescription drug field, and group life and accidental death insurance field,
and its facilities for the handling of claims. In evaluating these factors, the director may employ
the services of impartial, professional insurance analysts or actuaries or both. Any contract
executed by the director with a selected carrier shall be a contract to govern all eligible employees
subject to the provisions of this article. Nothing contained in this article shall prohibit any insurance
carrier from soliciting employees covered hereunder to purchase additional hospital and surgical,
major medical or life and accidental death insurance coverage.

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

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

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

(i) The director shall provide by contract or contracts entered into under the provisions of
this article the cost for coverage of children's immunization services from birth through age 16
years to provide immunization against the following illnesses: Diphtheria, polio, mumps, measles, rubella, tetanus, hepatitis-b, hemophilia influenzae-b, and whooping cough. Additional immunizations may be required by the Commissioner of the Bureau for Public Health for public health purposes. Any contract entered into to cover these services shall require that all costs associated with immunization, including the cost of the vaccine, if incurred by the healthcare provider, and all costs of vaccine administration be exempt from any deductible, per visit charge and/or copayment provisions which may be in force in these policies or contracts. This section does not require that other healthcare services provided at the time of immunization be exempt from any deductible and/or copayment provisions.

CHAPTER 33. INSURANCE.

ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.


(a) A policy, plan, or contract that is issued or renewed on or after January 1, 2019, and that is subject to this article shall provide coverage, through the age of 20, for amino acid-based formula for the treatment of severe protein-allergic conditions or impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract. This includes the following conditions, if diagnosed as related to the disorder by a physician licensed to practice in this state pursuant to either §30-3-1 et seq. or §30-14-1 et seq. of this code:

(1) Immunoglobulin E and Nonimmunoglobulin E-mediated allergies to multiple food proteins;

(2) Severe food protein-induced enterocolitis syndrome;

(3) Eosinophilic disorders as evidenced by the results of a biopsy; and

(4) Impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract (short bowel).
(b) The coverage required by §33-15-4p(a) of this code shall include medical foods for home use for which a physician has issued a prescription and has declared them to be medically necessary, regardless of methodology of delivery.

(c) For purposes of this section, “medically necessary foods” or “medical foods” shall mean prescription amino acid-based elemental formulas obtained through a pharmacy: Provided, That these foods are specifically designated and manufactured for the treatment of severe allergic conditions or short bowel.

(d) The provisions of this section shall not apply to persons with an intolerance for lactose or soy.

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§33-16-3bb. Coverage for amino acid-based formulas.

(a) A policy, plan, or contract that is issued or renewed on or after January 1, 2019, and that is subject to this article shall provide coverage, through the age of 20, for amino acid-based formula for the treatment of severe protein-allergic conditions or impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract. This includes the following conditions, if diagnosed as related to the disorder by a physician licensed to practice in this state pursuant to either §30-3-1 et seq. or §30-14-1 et seq. of this code:

(1) Immunoglobulin E and Nonimmunoglobulin E-medicated allergies to multiple food proteins;

(2) Severe food protein-induced enterocolitis syndrome;

(3) Eosinophilic disorders as evidenced by the results of a biopsy; and

(4) Impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract (short bowel).
(b) The coverage required by §33-16-3bb(a) of this code shall include medical foods for home use for which a physician has issued a prescription and has declared them to be medically necessary, regardless of methodology of delivery.

(c) For purposes of this section, “medically necessary foods” or “medical foods” shall mean prescription amino acid-based elemental formulas obtained through a pharmacy: Provided, That these foods are specifically designated and manufactured for the treatment of severe allergic conditions or short bowel.

(d) The provisions of this section shall not apply to persons with an intolerance for lactose or soy.

ARTICLE 24. HOSPITAL MEDICAL AND DENTAL CORPORATIONS.

§33-24-7q. Coverage for amino acid-based formulas.

(a) A policy, plan, or contract that is issued or renewed on or after January 1, 2019, and that is subject to this article shall provide coverage, through the age of 20, for amino acid-based formula for the treatment of severe protein-allergic conditions or impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract. This includes the following conditions, if diagnosed as related to the disorder by a physician licensed to practice in this state pursuant to either §30-3-1 et seq. or §30-14-1 et seq. of this code:

(1) Immunoglobulin E and Nonimmunoglobulin E-medicated allergies to multiple food proteins;

(2) Severe food protein-induced enterocolitis syndrome;

(3) Eosinophilic disorders as evidenced by the results of a biopsy; and

(4) Impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract (short bowel).
(b) The coverage required by §33-24-7q(a) of this code shall include medical foods for home use for which a physician has issued a prescription and has declared them to be medically necessary, regardless of methodology of delivery.

(c) For purposes of this section, “medically necessary foods” or “medical foods” shall mean prescription amino acid-based elemental formulas obtained through a pharmacy: Provided, That these foods are specifically designated and manufactured for the treatment of severe allergic conditions or short bowel.

(d) The provisions of this section shall not apply to persons with an intolerance for lactose or soy.

ARTICLE 25. HEALTHCARE CORPORATION.

§33-25-8n. Coverage for amino acid-based formulas.

(a) A policy, plan, or contract that is issued or renewed on or after January 1, 2019, and that is subject to this article shall provide coverage, through the age of 20, for amino acid-based formula for the treatment of severe protein-allergic conditions or impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract. This includes the following conditions, if diagnosed as related to the disorder by a physician licensed to practice in this state pursuant to either §30-3-1 et seq. or §30-14-1 et seq. of this code:

1. Immunoglobulin E and Nonimmunoglobulin E-mediated allergies to multiple food proteins;
2. Severe food protein-induced enterocolitis syndrome;
3. Eosinophilic disorders as evidenced by the results of a biopsy; and
4. Impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract (short bowel).
(b) The coverage required by §33-25-Bna of this code shall include medical foods for home use for which a physician has issued a prescription and has declared them to be medically necessary, regardless of methodology of delivery.

(c) For purposes of this section, “medically necessary foods” or “medical foods” shall mean prescription amino acid-based elemental formulas obtained through a pharmacy: *Provided, That* these foods are specifically designated and manufactured for the treatment of severe allergic conditions or short bowel.

(d) The provisions of this section shall not apply to persons with an intolerance for lactose or soy.

**ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.**


(a) A policy, plan, or contract that is issued or renewed on or after January 1, 2019, and that is subject to this article shall provide coverage, through the age of 20, for amino acid-based formula for the treatment of severe protein-allergic conditions or impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract. This includes the following conditions, if diagnosed as related to the disorder by a physician licensed to practice in this state pursuant to either §30-3-1 *et seq.* or §30-14-1 *et seq.* of this code:

(1) Immunoglobulin E and Nonimmunoglobulin E-medicated allergies to multiple food proteins;

(2) Severe food protein-induced enterocolitis syndrome;

(3) Eosinophilic disorders as evidenced by the results of a biopsy; and

(4) Impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract (short bowel).
(b) The coverage required by §33-25A-8p(a) of this code shall include medical foods for home use for which a physician has issued a prescription and has declared them to be medically necessary, regardless of methodology of delivery.

(c) For purposes of this section, “medically necessary foods” or “medical foods” shall mean prescription amino acid-based elemental formulas obtained through a pharmacy: Provided, That these foods are specifically designated and manufactured for the treatment of severe allergic conditions or short bowel.

(d) The provisions of this section shall not apply to persons with an intolerance for lactose or soy.
The Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.

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The within ............ approved this the ................

Day of ..................... 2018.

Governor