March 3, 2009

S 375. INSURANCE/COVER HEARING AIDS. Filed 3/3/09. *TO REQUIRE HEALTH BENEFIT PLANS AND THE STATE HEALTH PLAN TO COVER HEARING AIDS AND REPLACEMENT HEARING AIDS*.

Enacts new GS 58-3-280 to require every health benefit plan, including the State Health Plan for Teachers and State Employees (State Health Plan), to provide coverage for the full cost of one hearing aid per hearing-impaired ear. Limits the coverage to $2,500 per hearing aid every 36 months for covered individuals under the age of 22. Directs that the coverage is to include all related services that are prescribed by a licensed audiologist in this state. Directs that coverage include: (1) initial and replacement hearing aids not more frequently than every 36 months, (2) a new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child, and (3) provisions of services and supplies according to accepted standards. Provides that the same deductibles, coinsurance, and other limitations that apply to similar services covered under the health benefit plan apply to hearing aids and related services and supplies required to be covered under this proposed new section.

Makes a conforming change to GS 135-45.8(13), removing charges related to prescribing hearing aids from the list of limitations and exclusions under the State Health Plan.

Effective January 1, 2010,and applies to health benefit plans that are delivered, issued for delivery, or renewed on or after that date.

Intro. by Purcell. GS 58, 135

June 1, 2009

S 375. INSURANCE/COVER HEARING AIDS. Filed 3/3/09. Senate committee substitute makes the following changes to 1st edition. Amends proposed GS 58-3-280 to clarify that every health plan must provide coverage up to $2,500 (was, provide full cost, up to $2,500) for one hearing aid per ear every 36 months and clarifies that the coverage is subject to subsection (b) of the statute. Requires the coverage to include all medically necessary hearing aids and services ordered by a licensed audiologist. Also amends the coverage requirements to remove the provision requiring that services and supplies be provided according to accepted standards. Adds a new subsection (c) to provide that an insurer may use utilization review criteria to determine medical necessity, if it is done in compliance with current requirements under GS 58-50-61 (Utilization review, meaning a set of formal techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, providers, or facilities) and Part 4 of Article 50 of GS Chapter 58 (Health Benefit Plan External Review).

Changes the effective date to March 1, 2010 (was, January 1, 2010).