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HOUSE BILL NO. 2601

Offered January 9, 2019

A BILL to amend and reenact § 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3418.18, relating to health insurance coverage for hearing aids for certain individuals.

Patrons—Plum, Delaney, Hope, Kory, Levine, Rodman and Simon

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-4319 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding a section numbered 38.2-3418.18 as follows:

§ 38.2-3418.18. Coverage for hearing aids.

A. As used in this section:

"Covered individual" means a policyholder, subscriber, enrollee, participant, or other individual 18 years of age or younger who is covered by an individual or group accident and sickness insurance policy providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; individual or group accident and sickness subscription contract; or health care plan for health care services.

"Hearing aid" means any nonexperimental and wearable instrument or device offered to aid or compensate for impaired human hearing that is worn in or on the body. "Hearing aid" includes any parts, ear molds, repair parts, and replacement parts of such instrument or device, including nonimplanted bone anchored hearing aids, nonimplanted bone conduction hearing aids, and frequency modulation systems. "Hearing aid" does not include personal sound amplification products.

B. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for the billed charges of one hearing aid per hearing impaired ear not to exceed $3,000 per hearing aid for covered individuals. Such coverage shall provide the replacement for one hearing aid per hearing impaired ear every 48 months for covered individuals. The parent or guardian of a covered individual is responsible for billed charges in excess of such benefits. This section shall not prohibit an insurer, corporation, or health maintenance organization from providing coverage that is greater or more favorable to an individual than the coverage required under this section.

C. If a hearing aid cannot adequately meet the needs of the covered individual and the hearing aid cannot be adequately repaired or adjusted, the hearing aid shall be replaced. Coverage for the replacement shall be offered within two months from the date it is determined that the hearing aid cannot be repaired or adjusted.

D. The coverage required by this section shall include:

1. Medically necessary services and supplies, including the initial hearing aid evaluation, fitting, dispensing, programming, servicing, repairs, follow-up maintenance, adjustments, ear molds, ear mold impressions, auditory training, and probe microphone measurements to ensure appropriate gain and output, as well as verifying benefit from the system selected according to accepted professional standards. Such services shall be covered on a continuous basis, as needed, during each 48-month coverage period not to exceed $3,000 per hearing impaired ear or for the duration of the hearing aid warranty, whichever time period is longer;

2. An option for the covered individual to choose a higher priced hearing aid and to pay the difference between the price of the hearing aid or aids and the benefit amount as referenced in subsection B, without financial or contractual penalty to the insured or to the provider of the hearing aid; and

3. An option for the covered individual to purchase his hearing aid through any licensed audiologist or licensed hearing aid dealer or dispenser.

E. A policy, contract, or plan shall not deny or refuse coverage of, refuse to contract with, or refuse to renew or reissue or otherwise terminate or restrict coverage of a covered individual solely because the covered individual is or has been previously diagnosed with hearing loss.

F. No policy, contract, or plan shall impose upon any person receiving benefits pursuant to this section any copayment, fee, or condition that is not equally imposed upon all individuals in the same

benefit category.

G. An insurer, corporation, or health maintenance organization providing coverage for a hearing aid pursuant to this section is exempt from providing coverage for children's hearing aids required under this section if:

1. An actuary affiliated with the insurer, corporation, or health maintenance organization, who is a member of the American Academy of Actuaries and who meets the American Academy of Actuaries' professional qualification standards for rendering an actuarial opinion related to health insurance rate making certifies in writing to the Commissioner that:

a. Based on an analysis to be completed no more frequently than one time per year by each insurer, corporation, or health maintenance organization, for the most recent experience period of at least one year's duration, the costs associated with coverage of hearing aids required under this section exceeded one percent of the premiums charged over the experience period by the insurer, corporation, or health maintenance organization; and

b. Such costs solely would lead to an increase in average premiums charged of more than one percent for all policies, contracts, or health care plans commencing on inception or the next renewal date, based on the premium rating methodology and practices the insurer, corporation, or health maintenance organization, or governmental entity employs; and

2. The Commissioner approves the certification of the actuary.

H. Beginning January 1, 2020, to the extent that this section requires benefits that exceed the essential health benefits required under § 1302(b) of the federal Patient Protection and Affordable Care Act, P.L. 111-148 (the Act), the specific benefits that exceed the required essential health benefits shall not be required of a qualified health plan as defined in the Act when the qualified health plan is offered in the Commonwealth through a health benefit exchange operated pursuant to the provisions of the Act. Nothing in this subsection shall nullify the application of this section to plans offered outside such health benefit exchange.

I. This section shall not apply to any contract, policy, or plan offered by any employer with 10 or fewer employees.

J. The provisions of this section shall apply to any policy, contract, or plan delivered, issued for delivery, or renewed in the Commonwealth on and after January 1, 2020.

K. The provisions of this section shall not apply to short-term travel, accident-only, or limited or specified disease policies; contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans; or short-term nonrenewable policies of not more than six months' duration.

§ 38.2-4319. Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-316.1, 38.2-322, 38.2-325, 38.2-326, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.), 5 (§ 38.2-1322 et seq.), 5.1 (§ 38.2-1334.3 et seq.), and 5.2 (§ 38.2-1334.11 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.), 2 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 et seq.) of Chapter 14, Chapter 15 (§ 38.2-1500 et seq.), Chapter 17 (§ 38.2-1700 et seq.), §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3406.1, 38.2-3407.2 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.19, 38.2-3411, 38.2-3411.2, 38.2-3411.3, 38.2-3411.4, 38.2-3412.1, 38.2-3414.1, 38.2-3418.1 through ~~38.2-3418.17~~ *38.2-3418.18*, 38.2-3419.1, 38.2-3430.1 through 38.2-3454, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, 38.2-3541.2, 38.2-3542, 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 35.1 (§ 38.2-3556 et seq.), Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), and Chapter 58 (§ 38.2-5800 et seq.) shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

B. For plans administered by the Department of Medical Assistance Services that provide benefits pursuant to Title XIX or Title XXI of the Social Security Act, as amended, no provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-322, 38.2-325, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.), 5 (§ 38.2-1322 et seq.), 5.1 (§ 38.2-1334.3 et seq.), and 5.2 (§ 38.2-1334.11 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.), 2 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 et

seq.) of Chapter 14, §§ 38.2-3401, 38.2-3405, 38.2-3407.2 through 38.2-3407.5, 38.2-3407.6, 38.2-3407.6:1, 38.2-3407.9, 38.2-3407.9:01, and 38.2-3407.9:02, subdivisions F 1, F 2, and F 3 of § 38.2-3407.10, §§ 38.2-3407.11, 38.2-3407.11:3, 38.2-3407.13, 38.2-3407.13:1, 38.2-3407.14, 38.2-3411.2, 38.2-3418.1, 38.2-3418.2, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, 38.2-3541.2, 38.2-3542, 38.2-3543.2, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), and Chapter 58 (§ 38.2-5800 et seq.) shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

C. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

D. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

E. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.

F. For purposes of applying this section, "insurer" when used in a section cited in subsections A and B shall be construed to mean and include "health maintenance organizations" unless the section cited clearly applies to health maintenance organizations without such construction.