STATE OF NEW YORK

2325--A

2019-2020 Regular Sessions

IN ASSEMBLY

January 22, 2019

Introduced by M. of A. SOLAGES, D'URSO, RA -- read once and referred to the Committee on Insurance -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the insurance law, in relation to the mandatory coverage of hearing aids by insurers and other organizations

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Subsection (i) of section 3216 of the insurance law is amended by adding a new paragraph 36 to read as follows:

(36) (A) As used in this paragraph, "hearing aid" shall mean a non-disposable device that is of a design and circuitry to optimize audition and listening skills in the environment commonly experienced by children.

(B) This paragraph shall apply to the following entities:

(i) Insurers and nonprofit health service plans, including the office of group benefits, that provide hospital, medical, or surgical benefits to individuals or groups on an expense-incurred basis under health insurance policies or contracts that are issued or delivered in this state.

(ii) Managed care organizations as defined and licensed by state law that provide hospital, medical or surgical benefits to individuals or groups under contracts that are issued or delivered in this state.

(C) An entity subject to this paragraph shall provide coverage for hearing aids for patients who are covered under a policy or contract of insurance if the hearing aids are fitted and dispensed by a licensed audiologist certified by the American Speech-Language-Hearing Association following medical clearance by a physician licensed to practice medicine and an audiological evaluation medically appropriate to the age of the child, provided:

EXPLANATION--Matter in *italics* (underscored) is new; matter in brackets [-] is old law to be omitted.

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(i) an entity subject to this paragraph may limit the benefit payable under this paragraph to three thousand dollars per hearing aid for each hearing-impaired ear every twenty-four months.

(ii) an insured or enrolled individual may choose a hearing aid that is priced higher than the benefit payable under this paragraph and may pay the difference between the price of the hearing aid and the benefit payable under this paragraph without financial or contractual penalty to the provider of the hearing aid.

(iii) in the case of a health insurer or managed care organization that administers benefits according to contracts with health care providers, hearing aids covered pursuant to this paragraph shall be obtained from health care providers contracted with the health insurer or managed care organization. Such providers shall be subject to the same contracting and credentialing requirements that apply to other contracted health care providers.

(D) This paragraph does not prohibit an entity subject to the provisions of this paragraph from providing coverage that is greater or more favorable to an insured or enrolled individual than the coverage required under this paragraph.

(E) The provisions of this paragraph shall apply to any new policy, contract, program, or plan issued by an entity subject to the provisions of this paragraph on or after January first, two thousand twenty-one. Any such policy, contract, program or plan in effect prior to January first, two thousand twenty-one shall convert to the provisions of this paragraph on or before the renewal date thereof but in no event later than January first, two thousand twenty-one. Any policy affected by the provisions of this paragraph shall apply to an insured or participant under such policy, contract, program, or plan whether or not the hearing impairment is a pre-existing condition of the insured or participant.

§ 2. Section 3221 of the insurance law is amended by adding a new subsection (u) to read as follows:

(u) (1) As used in this subsection, "hearing aid" shall mean a non-disposable device that is of a design and circuitry to optimize audition and listening skills in the environment commonly experienced by children.

(2) This subsection shall apply to the following entities:

(A) Insurers and nonprofit health service plans, including the office of group benefits, that provide hospital, medical, or surgical benefits to individuals or groups on an expense-incurred basis under health insurance policies or contracts that are issued or delivered in this state.

(B) Managed care organizations as defined and licensed by state law that provide hospital, medical or surgical benefits to individuals or groups under contracts that are issued or delivered in this state.

(3) An entity subject to this subsection shall provide coverage for hearing aids for patients who are covered under a policy or contract of insurance if the hearing aids are fitted and dispensed by a licensed audiologist certified by the American Speech-Language-Hearing Association following medical clearance by a physician licensed to practice medicine and an audiological evaluation medically appropriate to the age of the child, provided:

(A) An entity subject to this subsection may limit the benefit payable under this subsection to three thousand dollars per hearing aid for each hearing-impaired ear every twenty-four months.

(B) An insured or enrolled individual may choose a hearing aid that is priced higher than the benefit payable under this subsection and may pay

the difference between the price of the hearing aid and the benefit payably under this subsection without financial or contractual penalty to the provider of the hearing aid.

(C) In the case of a health insurer or managed care organization that administers benefits according to contracts with health care providers, hearing aids covered pursuant to this subsection shall be obtained from health care providers contracted with the health insurer or managed care organization. Such providers shall be subject to the same contracting and credentialing requirements that apply to other contracted health care providers.

(4) This subsection does not prohibit an entity subject to the provisions of this subsection from providing coverage that is greater or more favorable to an insured or enrolled individual than the coverage required under this subsection.

(5) The provisions of this subsection shall apply to any new policy, contract, program, or plan issued by an entity subject to the provisions of this subsection on or after January first, two thousand twenty-one. Any such policy, contract, program or plan in effect prior to January first, two thousand twenty-one shall convert to the provisions of this subsection on or before the renewal date thereof but in no event later than January first, two thousand twenty-one. Any policy affected by the provisions of this subsection shall apply to an insured or participant under such policy, contract, program, or plan whether or not the hearing impairment is a pre-existing condition of the insured or participant.

§ 3. Section 4303 of the insurance law is amended by adding a new subsection (ss) to read as follows:

(ss)(1) As used in this subsection, "hearing aid" shall mean a non-disposable device that is of a design and circuitry to optimize audition and listening skills in the environment commonly experienced by children.

(2) This subsection shall apply to the following entities:

(A) Insurers and nonprofit health service plans, including the office of group benefits, that provide hospital, medical, or surgical benefits to individuals or groups on an expense-incurred basis under health insurance policies or contracts that are issued or delivered in this state.

(B) Managed care organizations as defined and licensed by state law that provide hospital, medical or surgical benefits to individuals or groups under contracts that are issued or delivered in this state.

(3) An entity subject to this subsection shall provide coverage for hearing aids for patients who are covered under a policy or contract of insurance if the hearing aids are fitted and dispensed by a licensed audiologist certified by the American Speech-Language-Hearing Association following medical clearance by a physician licensed to practice medicine and an audiological evaluation medically appropriate to the age of the child, provided:

(A) An entity subject to this subsection may limit the benefit payable under this subsection to three thousand dollars per hearing aid for each hearing-impaired ear every twenty-four months.

(B) An insured or enrolled individual may choose a hearing aid that is priced higher then the benefit payable under his subsection and may pay the difference between the price of the hearing aid and the benefit payable under this subsection without financial or contractual penalty to the provider of the hearing aid.

(C) In the case of the health insurer or managed care organization that administers benefits according to contracts with health care

providers, hearing aids covered pursuant to this subsection shall be obtained from health care providers contracted with the health insurer or managed care organization. Such providers shall be subject to the same contracting and credentialing requirements that apply to other contracted health care providers.

(4) This subsection does not prohibit an entity subject to the provisions of this subsection from providing coverage that is greater or more favorable to an insured or enrolled individual than the coverage required under this subsection.

(5) The provisions of this subsection shall apply to any new policy, contract, program, or plan issued by an entity subject to the provisions of this subsection on or after January first, two thousand twenty-one. Any such policy, contract, program or plan in effect prior to January first, two thousand twenty-one shall convert to the provisions of this subsection on or before the renewal date thereof but in no event later than January first, two thousand twenty-one. Any policy affected by the provision of this subsection shall apply to an insured or participant under such policy, contract, program, or plan whether or not the hearing impairment is a pre-existing condition of the insured or participant.

§ 4. This act shall take effect on the ninetieth day after it shall have become a law. Effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such date.