H.266

An act relating to health insurance coverage for hearing aids

It is hereby enacted by the General Assembly of the State of Vermont:

Sec. 1. PURPOSE

(a) The General Assembly recognizes the range of negative health outcomes that are associated with untreated hearing loss, including cognitive decline, dementia, falls, social isolation, and depression. All Vermonters should have access to hearing aids and related services, yet many health plans do not cover them. Vermont Medicaid currently covers hearing aids, while most health insurance plans offered in the commercial health insurance market do not. Federal law prohibits or preempts the State from regulating the benefits provided through plans covering more than half of the population of this State, including Medicare and self-funded employer plans. Medicare does not cover hearing aids and related services, and neither do most self-funded employer plans.

(b) In 2021 Acts and Resolves No. 74, Sec. E.227, the General Assembly directed the Department of Financial Regulation and other interested stakeholders to review Vermont's benchmark plan establishing the State's essential health benefits for qualified health plans offered through the Vermont Health Benefit Exchange and recommend whether to request federal approval to modify the benchmark plan to provide certain benefits, including hearing

aids. On March 2, 2022, the Green Mountain Care Board voted to approve a recommendation from the Department of Vermont Health Access to add coverage to the benchmark plan for up to one hearing aid per ear every three years and an annual hearing exam. The Department of Vermont Health Access is pursuing a change to Vermont's benchmark plan with the federal government for coverage for hearing aids and hearing exams to begin in Vermont's individual and small group insurance markets in January 2024.

(c) The purpose of this bill is to ensure continued coverage of hearing aids and related services in Vermont Medicaid, affirm ongoing efforts to make hearing aids and related services part of Vermont's benchmark plan, and make hearing aids and related services more accessible to Vermont residents by requiring coverage in large group health insurance plans, which comprise the remaining segment of the commercial health insurance market over which Vermont has regulatory authority and which do not currently offer these benefits.

Sec. 2. ESSENTIAL HEALTH BENEFITS; BENCHMARK PLAN; HEARING AIDS; REPORT

On or before November 1, 2022, the Department of Vermont Health Access shall provide an update to the Health Reform Oversight Committee regarding the status of the Department's application to the Centers for Medicare and Medicaid Services to modify the essential health benefits in Vermont's

benchmark plan to include coverage of hearing aids and related services beginning in plan year 2024.

Sec. 3. 33 V.S.A. § 1901k is added to read:

§ 1901k. MEDICAID COVERAGE FOR HEARING AIDS AND AUDIOLOGY SERVICES

Vermont Medicaid shall provide coverage for medically necessary hearing aids and audiology services when delivered by a health care professional practicing within the scope of the professional's license, including audiologic examinations, hearing screenings, fitting of hearing aids, prescriptions for hearing aid batteries, and other services as defined by the Department of Vermont Health Access by rule.

Sec. 4. 8 V.S.A. § 4088l is added to read:

§ 4088l. COVERAGE FOR HEARING AIDS

(a) As used in this section:

(1) "Health insurance plan" means a group health insurance policy or health benefit plan offered by a health insurance company, nonprofit hospital or medical service corporation, or health maintenance organization, but does not include:

(A) a qualified health benefit plan or reflective health benefit plan offered in accordance with 33 V.S.A. chapter 18, subchapter 1;

(B) a health benefit plan offered by an intermunicipal insurance association to one or more entities providing educational services pursuant to 24 V.S.A. chapter 121, subchapter 6; or

(C) a policy or plan providing coverage for a specified disease or other limited benefit coverage.

(2) "Hearing aid" means any small, wearable electronic instrument or device designed and intended for the ear for the purpose of aiding or compensating for impaired human hearing and any related parts, attachments, or accessories, including earmolds and associated remote microphones that pair with hearing aids to improve word comprehension in difficult listening situations in live or telecommunication settings. The term does not include cords, large-audience assisted listening devices, such as those designed for auditoriums, or stand-alone assisted listening devices that can function without a hearing aid.

(3) "Hearing aid professional services" means the practice of fitting, selecting, dispensing, selling, or servicing hearing aids, or a combination, including:

(A) evaluation for a hearing aid;

(B) fitting of a hearing aid;

(C) programming of a hearing aid;

(D) hearing aid repairs;

(E) follow-up adjustments, servicing, and maintenance of a hearing aid;

(F) ear mold impressions; and

(G) auditory rehabilitation and training.

(4) "Hearing care professional" means an audiologist or hearing aid dispenser licensed under 26 V.S.A. chapter 67, a physician licensed under 26 V.S.A. chapter 23 or 33, a physician assistant licensed under 26 V.S.A. chapter 31, or an advanced practice registered nurse licensed under 26 V.S.A. chapter 28, working within that professional's scope of practice.

(b) A health insurance plan shall cover the cost of a hearing aid for each ear and the associated hearing aid professional services when the hearing aid or aids are prescribed, fitted, and dispensed by a hearing care professional. The coverage shall include hearing aid batteries when prescribed by a hearing care professional.

(c)(1) The coverage provided by a health plan for hearing aids and associated services shall be limited only by medical necessity.

(2) A covered individual may select a hearing aid that exceeds the limits set forth in subdivision (1) of this subsection and pay the additional cost.

(d) The coverage required by this section shall not be subject to a deductible, co-payment, or coinsurance provision that is less favorable to a covered individual than the deductible, co-payment, or coinsurance provisions

that apply generally to other nonprimary care items and services under the health insurance plan.

(e) A covered individual who has exhausted all applicable internal review procedures provided by the health insurance plan shall have the right to an independent external review as set forth in section 4089f of this title.

Sec. 5. EFFECTIVE DATES

(a) Sec. 4 (8 V.S.A. § 4088l) shall take effect on January 1, 2024 and shall apply to all health insurance plans issued on and after January 1, 2024 on such date as a health insurer offers, issues, or renews the health insurance plan, but in no event later than January 1, 2025.

(b) The remaining sections shall take effect on passage.