CHAPTER 9

AN ACT HB 4104

Relating to hearing loss; creating new provisions; and amending ORS 743A.140 and 743A.141.

Be It Enacted by the People of the State of Oregon:

SECTION 1. ORS 743A.140 is amended to read:

743A.140. (1) [*Whenever any policy of health insurance provides for reimbursement of a cochlear implant, the insured under the policy is entitled to coverage of bilateral cochlear implants*] **A health benefit plan, as defined in ORS 743B.005, shall reimburse the cost of:**

(a) Bilateral cochlear implants if medically appropriate for the treatment of hearing loss; and

(b) Programming and reprogramming cochlear implants.

(2) For purposes of ORS 746.230, a reasonable investigation of a claim for bilateral cochlear implants must include a request to the treating surgeon for a written recommendation based on peer-reviewed medical literature and for the medical findings that support the recommendation.

(3) [*The provisions of this section apply to a health benefit plan as defined in ORS 743B.005*] **A health benefit plan shall reimburse the cost of repair and replacement parts for a cochlear implant if the repair or parts are not covered by a warranty and are necessary for the device to be functional for the user**.

(4) The provisions of this section are exempt from ORS 743A.001.

SECTION 2. ORS 743A.141 is amended to read:

743A.141. (1) As used in this section[,]**:**

(a) "Hearing aid" means any nondisposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments or accessory for the instrument or device, except batteries and cords.

(b) "Hearing assistive technology systems" means devices used with or without hearing aids or cochlear implants to improve the ability of a user with hearing loss to hear in various listening situations, such as being located a distance from a speaker, in an environment with competing background noise or in a room with poor acoustics or reverberation.

(2) A health benefit plan, as defined in ORS 743B.005, shall provide payment, coverage or reimbursement for**:**

(a) One hearing aid per hearing impaired ear if:

[*(a)*] **(A)** Prescribed, fitted and dispensed by a licensed audiologist with the approval of a licensed physician; and

[*(b)*] **(B)** Medically necessary for the treatment of hearing loss in an enrollee in the plan who is:

[*(A)*] **(i)** 18 years of age or younger; or

[*(B)*] **(ii)** 19 to 25 years of age and enrolled in a secondary school or an accredited educational institution.

(b) Ear molds and replacement ear molds:

(A) Up to four times per plan year for enrollees who are younger than eight years of age; and

(B) At least once per year for enrollees who are:

(i) Eight to 18 years of age; or

(ii) 19 to 25 years of age and enrolled in a secondary school or an accredited educational institution.

(c) One box of replacement batteries per year for each hearing aid.

(d) Necessary diagnostic and treatment services at least twice per year for enrollees who are younger than four years of age and at least once per year for enrollees who are four years of age or older, including:

(A) Hearing tests appropriate for an enrollee's age or developmental need;

(B) Hearing aid checks; and

(C) Aided testing.

(e) Bone conduction sound processors, if necessary for appropriate amplification of the hearing loss.

(f) Hearing assistive technology systems for an enrollee who is younger than 19 years of age, if necessary for appropriate amplification of the hearing loss.

[*(3)(a) The maximum benefit amount required by this section is $4,000 every 48 months, but a health benefit plan may offer a benefit that is more favorable to the enrollee. An insurer shall adjust the benefit amount on January 1 of each year to reflect the increase since January 1, 2010, in the U.S. City Average Consumer Price Index for All Urban Consumers for medical care as published by the Bureau of Labor Statistics of the United States Department of Labor.*]

[*(b)*] **(3)** An insurer may not impose any financial or contractual penalty upon an audiologist if an enrollee elects to purchase a hearing aid **or other device** priced higher than the benefit amount by paying the difference between the benefit amount and the price of the hearing aid **or other device**.

(4) A health benefit plan shall provide the benefits described in subsection (2)(a), (e) and (f) of this section:

(a) Every 36 months; or

(b) For hearing aids, more frequently than every 36 months if modifications to an existing hearing aid will not meet the needs of an enrollee who is:

(A) Under 19 years of age; or

(B) 19 to 25 years of age and enrolled in a secondary school or an accredited educational institution.

(5) An insurer must contract with pediatric audiologists in sufficient numbers and geographic locations in this state to comply with ORS 743B.202 and 743B.505.

(6) Insurance producers shall ensure that enrollees have access to navigators or other assisters to facilitate the diagnosis of hearing loss and needed amplification and ensure that technologies are available to treat hearing loss in enrollees who are 19 years of age or younger. Upon receiving a claim for reimbursement for the diagnosis of hearing loss, an insurer shall provide notice of the coverage limits to the enrollee or to the parent or legal guardian of the enrollee. With respect to enrollees with hearing loss who are younger than 19 years of age, an insurer shall provide educational materials to the parent or legal guardian of the enrollee and shall have a process in place to ensure that appropriate technologies are available.

[*(4)*] **(7)** The payment, coverage or reimbursement required under this section may be subject to provisions of the health benefit plan that apply to other durable medical equipment benefits covered by the plan, including but not limited to provisions relating to deductibles, coinsurance and prior authorization.

[*(5)*] **(8)** This section is exempt from ORS 743A.001.

SECTION 3. The amendments to ORS 743A.140 and 743A.141 by sections 1 and 2 of this 2018 Act apply to health benefit plans for which the Department of Consumer and Business Services has not approved rates as of the effective date of this 2018 Act.

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