HOUSE BILL 906

Short Title:	Reagan's Law.	(Public)
Sponsors:	Representatives Bell, White, Campbell, and Reives (Primary Sponsors). *For a complete list of sponsors, refer to the North Carolina General Assembly web site.*	
Referred to:	Health, if favorable, Insurance, if favorable, Rules, Calendar, and Operations of the House	

April 14, 2025

A BILL TO BE ENTITLED

AN ACT TO IMPROVE THE ACCESS OF NORTH CAROLINIANS WITH LIMB LOSS AND LIMB DIFFERENCE TO PROSTHETIC AND ORTHOTIC DEVICES AND CARE AND TO REPEAL STATE HEALTH BENEFIT PLAN REQUIREMENTS TO COVER EMERGENCY CARE THAT ARE DUPLICATIVE OF FEDERAL LAW.

The General Assembly of North Carolina enacts:

PART I. IMPROVE ACCESS TO PROSTHETIC AND ORTHOTIC DEVICES AND CARE

SECTION 1.(a) Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-286. Prosthetic and orthotic devices and care.**

(a) This section shall apply to all health benefit plans offered in this State other than those regulated under Part 5 of Article 50 of this Chapter, Small Employer Group Health Insurance Reform, or Article 50A of this Chapter, Multiple Employer Welfare Arrangements.

(b) Health benefit plan coverage shall include coverage for all prosthetic and orthotic devices required to be covered by federal law or regulation under Medicare Part B, as detailed under Part B of Subchapter XVIII of Chapter 7 of Title 42 of the U.S. Code and Subpart D of Part 414 of Subchapter B of Chapter IX of Title 42 of the Code of Federal Regulations. Coverage under this section shall include:

(1) All materials and components necessary to use a prosthetic or orthotic device.

(2) Instruction relating to the use of a prosthetic or orthotic device.

(3) Repair or replacement of a prosthetic or orthotic device meeting the requirements of subdivision (1) of this subsection.

(c) Coverage consistent with this section shall be required for all prosthetic or orthotic devices, including custom devices, determined by the insured's healthcare provider to be the most appropriate model to adequately meet the medical needs of the insured for completing activities of daily living or essential job-related activities.

(d) Coverage under this section shall not be limited to one prosthetic or orthotic device. In addition to coverage required under subsection (c) of this section, a health benefit plan shall provide coverage for additional prosthetic or orthotic devices, including custom devices determined by the insured's healthcare provider to be the most appropriate model to adequately meet the medical needs of the insured for either or both of the following:

(1) Performing physical activities, such as running, biking, swimming, and strength training.

(2) Maximizing the insured's whole-body health and function of one or more lower or upper limb.

(e) Coverage for prosthetic and orthotic devices, including custom devices, is considered a habilitative or rehabilitative benefit, including for the purposes of any federal requirement for the coverage of essential health benefits.

(f) An insurer shall not deny any health benefit claim for a prosthetic or orthotic device for an insured with limb loss or absence that would otherwise be covered for any insured without a disability seeking medical or surgical intervention to restore or maintain the ability to perform the same physical activity.

(g) A health benefit plan shall provide coverage for the replacement of a prosthetic or orthotic device, or part of a prosthetic or orthotic device, and all of the following shall apply to that coverage:

(1) The coverage shall be provided without regard to continuous use or useful lifetime restrictions so long as the prescribing healthcare provider determines that the provision of a replacement prosthetic or orthotic device, or a replacement part of a prosthetic or orthotic device, is necessary for any of the following reasons:

a. A change in the physiological condition of the insured.

b. An irreparable change in the condition of the device or part of the device.

c. The condition of the device, or part of the device, requires one or more repairs and the cost of the repair or repairs would be more than sixty percent (60%) of replacement cost of the device or the parts requiring replacement.

(2) An insurer may require confirmation from the prescribing healthcare provider prior to replacement only if the device or the part of the device being replaced is less than 3 years old.

(3) The coverage shall be provided for custom devices."

SECTION 1.(b) No later than February 1, 2028, each issuer that offers a health benefit plan subject to G.S. 58-3-286 shall report to the Commissioner of the Department of Insurance, in a form prescribed by the Commissioner, the number of claims and total amount of claims paid for benefits required under G.S. 58-3-286.

SECTION 1.(c) No later than March 1, 2028, the Commissioner of the Department of Insurance shall aggregate all data received under subsection (a) of this section by health benefit plan year and provide this information in a report to the Joint Legislative Oversight Committee on General Government and the Joint Legislative Oversight Committee on Health and Human Services.

SECTION 1.(d) This section is effective October 1, 2025, and applies to the earlier of the following:

(1) To insurance contracts issued, renewed, or amended on or after October 1, 2025.

(2) Upon the next yearly anniversary of the insurance contract date occurring after October 1, 2025. For the purposes of this section, the next yearly anniversary of the insurance contract date is deemed a renewal of the contract.

PART II. REPEAL STATE HEALTH BENEFIT PLAN REQUIREMENTS TO COVER EMERGENCY CARE THAT ARE DUPLICATIVE OF FEDERAL LAW/CONFORMING CHANGES

SECTION 2.(a) G.S. 58-3-190 is repealed.

SECTION 2.(b) G.S. 58-50-56.1(a)(1) reads as rewritten:

"(1) Exclusive provider benefit plan. – A health benefit plan offered by an insurer in which insureds must receive covered services from health care providers who are under a contract with the insurer and under which there is no requirement of coverage for care received from a health care provider who is not under contract with the insurer, except for emergency ~~services as required by G.S. 58-3-190~~ and medically necessary covered services as required by G.S. 58-3-200(d)."

SECTION 2.(c) G.S. 58-50-61(a)(13) reads as rewritten:

"(13) "Noncertification" means a determination by an insurer or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, or level of care or effectiveness, or does not meet the prudent layperson standard ~~for coverage of emergency services in G.S. 58-3-190,~~ under the federal Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd, and the requested service is therefore denied, reduced, or terminated. A "noncertification" is not a decision rendered solely on the basis that the health benefit plan does not provide benefits for the health care service in question, if the exclusion of the specific service requested is clearly stated in the certificate of coverage. A "noncertification" includes any situation in which an insurer or its designated agent makes a decision about a covered person's condition to determine whether a requested treatment is experimental, investigational, or cosmetic, and the extent of coverage under the health benefit plan is affected by that decision."

SECTION 2.(d) G.S. 58-50-61(a)(17)g. reads as rewritten:

"g. Retrospective review. – Utilization review of medically necessary services and supplies that is conducted after services have been provided to a patient, but not the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment. Retrospective review includes the review of claims for emergency services to determine whether the prudent layperson standard ~~in G.S. 58-3-190~~ under the federal Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd, has been met."

SECTION 2.(e) G.S. 108D-65(6)f.1. is repealed.

PART III. EFFECTIVE DATE

SECTION 3. Except as otherwise provided, this act is effective when it becomes law.