By: Kolkhorst S.B. No. 552

A BILL TO BE ENTITLED

AN ACT

relating to health benefit plan coverage of hearing aids and cochlear implants for certain individuals.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Chapter 1367, Insurance Code, is amended by adding Subchapter F to read as follows:

SUBCHAPTER F. HEARING AIDS AND COCHLEAR IMPLANTS

Sec. 1367.251. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to a health benefit plan, including a small employer health benefit plan written under Chapter 1501 or coverage provided through a health group cooperative under Subchapter B of that chapter, that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a fraternal benefit society operating under Chapter 885;

(4) a Lloyd's plan operating under Chapter 941;

(5) a stipulated premium insurance company operating

under Chapter 884;

(6) a reciprocal exchange operating under Chapter 942;

(7) a health maintenance organization operating under Chapter 843;

(8) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(9) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

(b) This subchapter applies to coverage under a group health benefit plan described by Subsection (a) provided to a resident of this state, regardless of whether the group policy, agreement, or contract is delivered, issued for delivery, or renewed within or outside this state.

(c) This subchapter applies to group health coverage made available by a school district in accordance with Section 22.004, Education Code.

(d) This subchapter applies to a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code.

(e) Notwithstanding Section 22.409, Business Organizations Code, or any other law, this subchapter applies to health benefits provided by or through a church benefits board under Subchapter I, Chapter 22, Business Organizations Code.

(f) Notwithstanding Sections 157.008 and 157.106, Local Government Code, or any other law, this subchapter applies to a county employee health benefit plan provided under Chapter 157, Local Government Code.

(g) Notwithstanding Section 75.104, Health and Safety Code, or any other law, this subchapter applies to a regional or local health care program operated under that section.

(h) Notwithstanding Section 172.014, Local Government Code, or any other law, this subchapter applies to health and accident coverage provided by a risk pool created under Chapter 172, Local Government Code.

(i) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this subchapter applies to:

(1) a basic coverage plan under Chapter 1551;

(2) a basic plan under Chapter 1575;

(3) a primary care coverage plan under Chapter 1579; and

(4) basic coverage under Chapter 1601.

(j) Notwithstanding any other law, a standard health benefit plan provided under Chapter 1507 must provide the coverage required by this subchapter.

Sec. 1367.252. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(B) as a supplement to a liability insurance policy;

(C) for credit insurance;

(D) only for dental or vision care;

(E) only for hospital expenses; or

(F) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy;

(5) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1367.251; or

(6) the state Medicaid program, including the Medicaid managed care program operated under Chapter 533, Government Code.

Sec. 1367.253. COVERAGE REQUIRED. (a) A health benefit plan must provide coverage for the cost of a medically necessary hearing aid or cochlear implant and related services and supplies for a covered individual who is 18 years of age or younger.

(b) Coverage required under this section:

(1) must include:

(A) fitting and dispensing services and the provision of ear molds as necessary to maintain optimal fit of hearing aids;

(B) any treatment related to hearing aids and cochlear implants, including coverage for habilitation and rehabilitation as necessary for educational gain; and

(C) for a cochlear implant, an external speech processor and controller with necessary components replacement

every three years; and

(2) is limited to:

(A) one hearing aid in each ear every three years; and

(B) one cochlear implant in each ear with internal replacement as medically or audiologically necessary.

(c) Except as provided by Subsection (b), coverage required under this section:

(1) may not be less favorable than coverage for physical illness generally under the plan;

(2) must be subject to durational limits and coinsurance factors no less favorable than coverage provided for physical illness generally under the plan; and

(3) may not be subject to a deductible requirement or dollar limit.

(d) This section does not apply to a qualified health plan defined by 45 C.F.R. Section 155.20 if a determination is made under 45 C.F.R. Section 155.170 that:

(1) this subchapter requires the plan to offer benefits in addition to the essential health benefits required under 42 U.S.C. Section 18022(b); and

(2) this state must make payments to defray the cost of the additional benefits mandated by this subchapter.

SECTION 2. The change in law made by this Act applies only to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2018. A health benefit plan delivered, issued for delivery, or renewed before January 1, 2018, is governed

by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 3. This Act takes effect September 1, 2017.