BILL ANALYSIS

C.S.H.B. 490
By: Anderson, Rodney
Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Interested parties note that hearing loss in childhood interferes with a child's development and that children who receive early intervention generally experience positive outcomes. Concerns have been raised regarding the lack of coverage by certain insurance plans for the cost of a medically necessary hearing aid or cochlear implant and related services and supplies. C.S.H.B. 490 seeks to address this concern by requiring a health benefit plan to provide such coverage for a covered individual who is 18 years of age or younger.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

C.S.H.B. 490 amends the Insurance Code to require a health benefit plan to 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. The bill requires the coverage to include fitting and dispensing services and the provision of ear molds as necessary to maintain optimal fit of hearing aids; any treatment related to hearing aids and cochlear implants, including coverage for habilitation and rehabilitation as necessary for educational gain; and, for a cochlear implant, an external speech processor and controller with necessary components replacement every three years. The bill limits the required coverage to one hearing aid in each ear every three years and one cochlear implant in each ear with internal replacement as medically or audiologically necessary. The bill prohibits the coverage from being less favorable than coverage for physical illness generally under the plan and requires the coverage to be subject to durational limits and coinsurance factors no less favorable than coverage provided for physical illness generally under the plan.

C.S.H.B. 490 exempts a qualified health plan from the required hearing aid and cochlear implant coverage if a determination is made under specified federal regulations that the bill's provisions require the plan to offer benefits in addition to the essential health benefits required under the federal Patient Protection and Affordable Care Act and that the state is required to make payments to defray the cost of the additional benefits mandated by the bill. The bill establishes, and provides certain exceptions to, the applicability of its provisions. The bill applies only to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2018.

EFFECTIVE DATE

September 1, 2017.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 490 may differ from the original in minor or nonsubstantive ways, the following comparison is organized and formatted in a manner that indicates the substantial differences between the introduced and committee substitute versions of the bill.

INTRODUCED	HOUSE COMMITTEE SUBSTITUTE
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	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.	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.	(c) 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.	(d) 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.	(e) 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.	
(See Sec. 1367.251(j) below)	(f) Notwithstanding any other law, a standard health benefit plan provided under Chapter 1507 must provide the coverage required by this subchapter.
(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.	(g) 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.	*(See Sec. 1367.251(f) above)*

Sec. 1367.252. EXCEPTION.

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

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(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; and

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

(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. Same as introduced version.

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.	SECTION 3. Same as introduced version.