

## **BILL ANALYSIS**

Senate Research Center

H.B. 490  
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Business & Commerce  
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Engrossed

### **AUTHOR'S / SPONSOR'S STATEMENT OF INTENT**

Hearing loss in childhood can be very detrimental to a child's development. Children who receive early intervention for hearing loss generally experience more positive outcomes than those who do not. Concerns have been raised that the lack of health insurance coverage for medically necessary hearing aids and cochlear implants is a major barrier to overcoming the challenges for children with hearing loss. H.B. 490 amends the Insurance Code to require a health benefit plan to cover hearing aids and cochlear implants for individuals who are 18 years of age or younger.

H.B. 490 amends current law relating to health benefit plan coverage of hearing aids and cochlear implants for certain individuals.

### **RULEMAKING AUTHORITY**

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

### **SECTION BY SECTION ANALYSIS**

SECTION 1. Amends Chapter 1367, Insurance Code, by adding Subchapter F, as follows:

#### **SUBCHAPTER F. HEARING AIDS AND COCHLEAR IMPLANTS**

Sec. 1367.251. APPLICABILITY OF SUBCHAPTER. (a) Provides that this subchapter applies only to a health benefit plan (HBP), including a small employer HBP written under Chapter 1501 (Health Insurance Portability and Availability Act) or coverage provided through a health group cooperative under Subchapter B (Coalitions and Cooperatives) of that chapter, that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including certain insurance policies, insurance agreements, or group evidence of coverage that is offered by certain entities.

(b) Provides that this subchapter applies to coverage under a group HBP 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) Provides that this subchapter applies to a self-funded HBP sponsored by a professional employer organization under Chapter 91 (Professional Employer Organizations), Labor Code.

(d) Provides that, notwithstanding Section 22.409 (Insurance Code Not Applicable), Business Organizations Code, or any other law, this subchapter applies to health benefits provided by or through a church benefits board under Subchapter I (Church Benefits Boards), Chapter 22 (Nonprofit Corporations), Business Organizations Code.

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

(f) Requires a standard HBP provided under Chapter 1507 (Consumer Choice of Benefits Plans), notwithstanding any other law, to provide the coverage required by this subchapter.

(g) Provides that, notwithstanding any provision in Chapter 1551 (Texas Employees Group Benefits Act), 1575 (Texas Public School Employees Group Benefits Program), 1579 (Texas School Employees Uniform Group Health Coverage), or 1601 (Uniform Insurance Benefits Act for Employees of The University of Texas System and The Texas A&M University System) or any other law, this subchapter applies to a basic coverage plan under Chapter 1551, a basic plan under Chapter 1575, a primary care coverage plan under Chapter 1579, and basic coverage under Chapter 1601.

Sec. 1367.252. EXCEPTION. Provides that this subchapter does not apply to:

- (1) a plan that provides coverage for certain payments or expenses;
- (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 of insurance (commissioner) determines that the policy provides benefit coverage so comprehensive that the policy is an HBP as described by Section 1367.251; or
- (6) the state Medicaid program, including the Medicaid managed care program operated under Chapter 533 (Medicaid Managed Care Program), Government Code.

Sec. 1367.253. COVERAGE REQUIRED. (a) Requires that an HBP 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) Provides that coverage under this section:

- (1) is required to include certain treatments and services related to hearing aids or cochlear implants; and
- (2) is limited to one hearing aid in each ear every three years and one cochlear implant in each ear with internal replacement as medically or audiological necessary.

(c) Provides that, except as provided by Subsections (b) and (d), coverage required under this section is prohibited from being less favorable than coverage for physical illness generally under the plan and is required to be subject to durational limits and coinsurance factors no less favorable than the coverage provided for physical illness generally under the plan.

(d) Provides that coverage required under this section is subject to any provision that applies generally to coverage provided for durable medical equipment

benefits under this plan, including a provision relating to deductibles, coinsurance, or prior authorization.

(e) Provides that 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 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 that this state is required to make payments to defray the cost of the additional benefits mandated by this subchapter.

SECTION 2. Makes application of this Act prospective to January 1, 2018.

SECTION 3. Effective date: September 1, 2017.