BILL ANALYSIS

Senate Research Center
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S.B. 51
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Health & Human Services
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AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Although current law requires health benefit plans to cover hearing aids, some deny enrollees' claims because the requested hearing aids are more expensive than the ones available under the plan, even if the patient is willing to pay the difference.

S.B. 51 would prohibit a health benefit plan from denying an enrollee's claim for hearing aids solely because they are more expensive than the available benefit. The health plan would explicitly not be required to pay the difference. This change would allow more Texans to acquire hearing aids that fit their needs.

As proposed, S.B. 51 amends current law relating to health benefit coverage for hearing aids for children and adults.

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 1365, Insurance Code, by designating Sections 1365.001 through 1365.004 as Subchapter A and adding a subchapter heading, to read as follows:

SUBCHAPTER A. GENERAL PROVISIONS

SECTION 2. Amends Sections 1365.001 and 1365.002, Insurance Code, as follows:

Sec. 1365.001. New heading: APPLICABILITY OF SUBCHAPTER. Makes a conforming change to this section.

Sec. 1365.002. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. Makes a conforming change to this section.

SECTION 3. Amends Chapter 1365, Insurance Code, by adding Subchapter B, as follows:

SUBCHAPTER B. HEARING AID COVERAGE

Sec. 1365.051. APPLICABILITY. (a) Provides that this subchapter applies only to a health benefit plan 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 (Group Hospital Service Corporations);

(3) a health maintenance organization operating under Chapter 843 (Health Maintenance Organizations);

(4) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844 (Certification of Certain Nonprofit Health Corporations);

(5) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846 (Multiple Employer Welfare Arrangements);

(6) a stipulated premium company operating under Chapter 884 (Stipulated Premium Insurance Companies);

(7) a fraternal benefit society operating under Chapter 885 (Fraternal Benefit Societies);

(8) a Lloyd's plan operating under Chapter 941 (Lloyd's Plan); or

(9) an exchange operating under Chapter 942 (Reciprocal and Interinsurance Exchanges).

(b) Provides that 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) Provides that, notwithstanding any other law, this subchapter applies to:

(1) a small employer health benefit plan subject to Chapter 1501 (Health Insurance Portability and Availability Act), including coverage provided through a health group cooperative under Subchapter B (Coalitions and Cooperatives) of Chapter 1501;

(2) a standard health benefit plan issued under Chapter 1507 (Consumer Choice of Benefits Plans);

(3) a basic coverage plan under Chapter 1551 (Texas Employees Group Benefits Act);

(4) a basic plan under Chapter 1575 (Texas Public School Employees Group Benefits Program);

(5) a primary care coverage plan under Chapter 1579 (Texas School Employees Uniform Group Health Coverage);

(6) a plan providing basic coverage under Chapter 1601 (Uniform Insurance Benefits Act for Employees of The University of Texas System and the Texas A&M University System);

(7) health benefits provided by or through a church benefits board under Subchapter I (Church Benefits Boards), Chapter 22, Business Organizations Code;

(8) a regional or local health care program operated under Section 75.104 (Health Care Services), Health and Safety Code; and

(9) a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91 (Professional Employer Organizations), Labor Code.

Sec. 1365.052. EXCEPTION. Provides that this subchapter does not apply to a plan that provides coverage for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury or only for hospital expenses or to the state Medicaid program, including the Medicaid managed care program operated under Chapter 533 (Medicaid Managed Care Program), Government Code.

Sec. 1365.053. CHOICE OF HEARING AID. (a) Prohibits a health benefit plan that provides coverage for hearing aids from denying an enrollee's claim for a hearing aid solely on the basis that the price of the hearing aid is more than the benefit available under the health benefit plan.

(b) Provides that notwithstanding Section 1367.253(d) (relating to subjecting coverage required for hearing aids and cochlear implants to certain provisions applicable to durable medical equipment), this section applies to a health benefit plan subject to Subchapter F (Hearing Aids and Cochlear Implants), Chapter 1367.

(c) Provides that nothing in this section requires a health benefit plan to pay an enrollee's claim for a hearing aid in an amount that is more than the benefit available under the health benefit plan.

SECTION 4. Makes application of this Act prospective to January 1, 2024.

SECTION 5. Effective date: September 1, 2023.