ASSEMBLY BILL No. 368

Introduced by Assembly Member Carter

February 14, 2007

An act to add Section 1367.195 to the Health and Safety Code, and to add Section 10123.75 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 368, as introduced, Carter. Hearing aids.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the regulation of health care service plans by the Department of Managed Health Care. Existing law requires a health care service plan to provide specified coverage to its enrollees and subscribers. Existing law provides that a willful violation of the act is a crime.

Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health insurance policy to provide specified coverage to insureds.

This bill would require health care service plans and health insurers, on or after January 1, 2009, to offer, at minimal cost, coverage up to $1,000 for hearing aids, as defined, to all enrollees, subscribers, and insureds under 18 years of age. The bill would provide that the requirement to provide this coverage would not apply to certain types of insurance.

Because this bill would place additional requirements on health care service plans, the violation of which would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1367.195 is added to the Health and Safety Code, to read:

1367.195. (a) On or after January 1, 2009, every health care service plan contract that covers hospital, medical, or surgical expenses on an individual or group basis, that is issued, amended, or renewed shall offer coverage for hearing aids, up to one thousand dollars ($1,000), to all enrollees and subscribers under 18 years of age. This benefit may be restricted to one claim during a 48-month period. The increase in premium for the enrollee or subscriber in need of this benefit shall be minimal.

(b) For purposes of this section, "hearing aid" means any nonexperimental, wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing, but excluding batteries and cords.

(c) It shall remain within the sole discretion of the health care service plan as to the provider of hearing aids with which it chooses to contract. Reimbursement shall be provided according to the respective principles and policies of the health care service plan. Nothing contained in this section shall preclude a health care service plan from conducting managed care, medical necessity, or utilization review.

SEC. 2. Section 10123.75 is added to the Insurance Code, to read:

10123.75. (a) On or after January 1, 2009, every insurer that issues, amends, or renews an individual or group policy of health insurance that covers hospital, medical, or surgical expenses shall offer coverage for hearing aids, up to one thousand dollars ($1,000), to all insureds under 18 years of age. This benefit may be restricted to one claim during a 48-month period. The increase in premium for the insured in need of this benefit shall be minimal.

(b) For purposes of this section, "hearing aid" means any nonexperimental, wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing, but excluding batteries and cords.

(c) It shall remain within the sole discretion of the health insurer as to the provider of hearing aids with which it chooses to contract. Reimbursement shall be provided according to the respective principles and policies of the health insurer. Nothing contained in this section shall preclude a health insurer from conducting managed care, medical necessity, or utilization review.

(d) This section shall not apply to Medicare supplement, vision-only, dental-only, Champus-supplement insurance, or to insurance excluded from the definition of health insurance pursuant to subdivision (b) of Section 106.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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