**A** **BILL**

TO AMEND THE CODE OF LAWS OF SOUTH CAROLINA, 1976, BY ADDING SECTION 38‑71‑48 SO AS TO PROVIDE DEFINITIONS, TO REQUIRE GROUP HEALTH INSURANCE AND GROUP HEALTH BENEFIT PLANS TO COVER HEARING AIDS AND REPLACEMENT HEARING AIDS FOR AN INSURED WITH IMPAIRED HEARING AND WHO IS TWENTY‑ONE YEARS OF AGE OR LESS, AND TO PROVIDE FOR THE SCOPE OF COVERAGE, AMONG OTHER THINGS.

Whereas, in 2001, the South Carolina General Assembly mandated universal newborn hearing screening for all babies to provide early detection of hearing loss and to enable these newborns and their families and caregivers to obtain needed multidisciplinary evaluation, treatment, and intervention services at the earliest opportunity; and

Whereas, hearing aids are critical to the language development of children with hearing loss whose parents have chosen listening and spoken language for them; and

Whereas, hearing aid insurance coverage will bridge the gap between early identification and diagnosis of hearing loss through the universal newborn hearing screening by increasing accessibility to amplification devices that can correct the deficiency; and

Whereas, the earlier in age hearing loss is identified and intervention begun, the more likely it is that the delays in speech and language development will be diminished; and

Whereas, research indicates that children identified with hearing loss who begin services before six months old develop language comparable with their hearing peers; and

Whereas, early intervention, including hearing amplification, provides a significant savings for each child annually in reduced or eliminated public expenditure for health care, special education services, and other related services; and

Whereas, children who do not receive early intervention, including hearing amplification, cost schools hundreds of thousands of dollars each during their schooling and are faced with overall lifetime costs reaching into the **millions of dollars in s**pecial education service costs, lost wages, and compounding health complications; and

Whereas, if left undetected, hearing impairments can negatively impact speech and language acquisition, academic achievement, and social and emotional development. Further, hearing loss may create a safety concern when children are unable to hear audible warnings such as fire alarms and sirens. If detected, these negative impacts can be diminished and even eliminated through early intervention; and

Whereas, the financial hardship is greatest for those families above the federal poverty levels that do not qualify for state assistance and who do not have insurance coverage for hearing aids; and

Whereas, the eighteen states that provide hearing aid insurance coverage for children help increase the accessibility and affordability of hearing health care for its citizens who use them. Now, therefore,

Be it enacted by the General Assembly of the State of South Carolina:

SECTION 1. Article 1, Chapter 71, Title 38 of the 1976 Code is amended by adding:

“Section 38‑71‑48. (A) As used in this section:

(1) ‘Hearing loss’ means any degree of permanent impairment of the ability to apprehend sound.

(2) ‘Hearing aid’ means any nonexperimental and wearable instrument or device designed for the ear and offered to aid or compensate for impaired human hearing, including any parts, ear molds, repair parts, and replacement parts of this instrument or device. ‘Hearing aid’ excludes batteries, cords, and other assistive listening devices.

(3) ‘Audiologist’ means an individual licensed to practice audiology in this State pursuant to Chapter 67, Title 40.

(4) ‘Audiologic evaluation’ means an evaluation consisting of procedures to:

(a) assess the status of the auditory system, the site of an auditory disorder, the type and degree of hearing loss, and the potential effects of hearing loss on communication; and

(b) identify appropriate treatment and referral options. Referral options for evaluation should include linkage to state Part C Individuals with Disabilities Education Act coordinating agencies or other appropriate agencies or medical entities.

(5) ‘Auditory habilitation’ means intervention including the use of procedures, techniques, and technologies to facilitate the receptive and expressive communication abilities of a child with hearing loss.

(6) ‘Insurer’ means an insurance company, a health maintenance organization, and other entity that provides health insurance coverage as defined in Section 38‑71‑670(6), is licensed to engage in the business of insurance in this State, and is subject to state insurance regulation.

(7) ‘Health maintenance organization’ means an organization as defined in Section 38‑33‑20(8).

(8) ‘Health insurance plan’ means a group health insurance policy or group health benefit plan offered by an insurer. A ‘health insurance plan’ includes the State Health Plan but does not otherwise include a health insurance plan offered in the individual market as defined in Section 38‑71‑670(11), a health insurance plan that is individually underwritten, or a health insurance plan provided to a small employer as defined by Section 38‑71‑1330(17).

(9) ‘State Health Plan’ means the employee and retiree insurance program provided in Article 5, Chapter 11, Title 1.

(10) ‘Practice of fitting, dispensing, servicing, and sale of hearing instruments’ means the measurement of human hearing with an audiometer for the purpose of making selections, recommendations, adoptions, services, and sales of hearing instruments, including the making of ear molds, as a part of the hearing instrument. An audiometer used in this section must be calibrated to the current American National Standard Institute standards.

(B) A health insurance plan must provide coverage for hearing aids and replacement hearing aids for a covered individual with impaired hearing. This coverage must include fitting, dispensing, servicing, and repairs, including providing ear molds as necessary to maintain optimal fit, and prescribed and dispensed by the treating licensed audiologist of the insured. A health insurance plan may not deny or refuse coverage on, refuse to contract with, or refuse to renew or refuse to reissue or otherwise terminate or restrict coverage on a covered individual solely because he is or has been previously diagnosed with hearing loss.

(C) A covered individual must be diagnosed with permanent hearing loss by a licensed audiologist to be eligible for coverage under this section.

(D) An insurer must provide this coverage to an eligible individual who is twenty‑one years of age or less.

(E) Coverage for an initial hearing aid and a replacement is subject to a one thousand five‑hundred‑dollar minimum amount and up to a two thousand five‑hundred‑dollar maximum amount for a hearing impaired ear benefit in a thirty‑six month period. The insured may choose a hearing aid exceeding the coverage amount of the insured but must pay the difference in cost above the amount of coverage required by this section.

(F) A health insurance plan shall provide a new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the covered individual as determined by the treating licensed audiologist.

(G) A health insurance plan may not impose a financial or contractual penalty to an insured or to the audiologist providing the hearing aid if a covered individual elects to purchase a hearing aid priced higher than the benefit amount by paying the difference between the benefit amount and the price of the hearing aid.

(H) Coverage required pursuant to subsection (B):

(1) may not be subject to dollar limits, deductibles, and coinsurance provisions that are less favorable to an insured than the dollar limits, deductibles, and coinsurance provisions that apply to physical illness generally under the health insurance plan, except as otherwise provided in subsection (E); and

(2) may be subject to other general exclusions and limitations of the health insurance plan, including, but not limited to, coordination of benefits, participating provider requirements, restrictions on services provided by family or household members, review of health care services including review of medical necessity, case management, and other managed care provisions.”

SECTION 2. This act takes effect July 1, 2012, and applies to health insurance plans issued, renewed, delivered, or entered into on or after the effective date of this act.

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