

Date of Hearing: June 30, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 331 (Menjivar) – As Amended June 1, 2026

SENATE VOTE: 27-0

SUBJECT: Health care coverage: hearing aids.

SUMMARY: Requires a large group health plan or health insurer to cover medically necessary hearing aids for kids under 21 years of age. Specifically, **this bill:**

- 1) Requires a health plan or insurer to cover hearing aids for enrollees under 21 years of age, if medically necessary. Requires the covered service to be provided by a contracted provider, unless the contract allows for out-of-network coverage. Requires, for children under five years of age, a contracted provider to include a pediatric audiologist.
- 2) Specifies that the maximum required coverage amount under this section is \$3,000 per individual hearing aid. Permits an enrollee to purchase a hearing aid that exceeds the maximum coverage amount, but to be responsible for the difference between the cost of the hearing aid and the maximum coverage amount.
- 3) Prohibits hearing aids covered from being subject to a deductible, coinsurance, or copayment requirement. Prohibits coverage of hearing aids from being subject to financial or treatment limitations, including a dollar limit that is set below \$3,000 per individual hearing aid.
- 4) Prohibits a “high deductible health plan” as defined under federal law from imposing cost sharing as described in 3) above, unless not applying cost sharing would conflict with federal requirements for high deductible health plans.
- 5) Requires coverage for hearing aids to include an initial assessment, new earmolds, new hearing aids if alterations to existing hearing aids cannot meet the needs of the enrollee, a new hearing aid if the existing one is no longer working, and fittings, adjustments, auditory training, and maintenance of the hearing aids. Specifies that the new three-year hearing aid limit does not apply if alterations to existing hearing aids cannot meet the needs of the enrollee or an existing hearing aid is no longer working.
- 6) Defines “hearing aid” as an electronic device designed to aid or compensate for impaired human hearing and any parts, attachments, or accessories, including earmolds, but excluding batteries and cords. Specifies that this includes both hearing aids traditionally worn behind the ear and nonimplanted auditory osseointegrated (integrated with bone) devices.
- 7) Exempts Medicare supplemental plans, specialized health care service plans or insurers that cover only dental or vision benefits, and Medi-Cal managed care plans.

EXISTING LAW:

- 1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 and the California Department of

Insurance (CDI) to regulate health insurers. [Health and Safety Code (HSC) § 1340, *et seq.*, and Insurance Code (INS) § 106, *et seq.*]

- 2) Establishes the Medi-Cal program, administered by the Department of Health Care Services (DHCS), under which low-income individuals are eligible for medical coverage. [Welfare and Institutions Code (WIC) § 14000, *et seq.*]
- 3) Establishes a schedule of benefits under the Medi-Cal program, which includes benefits required under federal law and benefits provided at state option but for which federal financial participation is available. [WIC § 14132]
- 4) Establishes as California's essential health benefits (EHBs) benchmark under the Patient Protection and Affordable Care Act (ACA), the Kaiser Small Group Health Maintenance Organization, existing California health insurance mandates, and the 10 ACA mandated benefits, including durable medical equipment (DME) coverage. Specifies EHBs in the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and, pediatric services, including oral and vision care. [HSC § 1367.005 and INS § 10112.27]
- 5) Expresses the intent of the Legislature to review California's EHB benchmark plan and establish a new benchmark plan for the 2027 plan year for health plans and insurers. Requires, commencing January 1, 2027, if the United States Department of Health and Human Services (HHS) approves a new EHB benchmark plan for the state, as specified, the benchmark plan for health insurers to include certain additional benefits, including coverage for hearing aids, fertility services and specified DME. [*Ibid.*]
- 6) Defines "basic health care services" as all of the following:
 - a) Physician services, including consultation and referral;
 - b) Hospital inpatient services and ambulatory care services;
 - c) Diagnostic laboratory and therapeutic radiologic services;
 - d) Home health services;
 - e) Preventive health services;
 - f) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage. Basic health care services includes ambulance and ambulance transport services provided through the 911 emergency response system; and,
 - g) Hospice care, as specified. [HSC § 1345]
- 7) Establishes California Children Services (CCS), administered by the DHCS, under which individuals under the age of 21 who have eligible medical conditions established in regulation and meet financial requirements, are eligible to receive medically necessary services and treatments. [HSC § 123800, *et seq.*]

FISCAL EFFECT: Unknown. As recently amended, this bill has not been analyzed by a fiscal committee.

COMMENTS:

- 1) PURPOSE OF THIS BILL.** According to the author, numerous experts agree that pediatric hearing loss is considered a developmental emergency requiring timely intervention to prevent permanent developmental delays. These preventable consequences are not only devastating for children and families; they are costly to society. The author notes that California requires hospitals and perinatal services to screen all newborns to identify those that are Deaf or Hard of Hearing (DHH). Despite California identifying nearly all DHH children as newborns, there remains a lack of access to hearing aids once they have been identified as DHH. The author continues that private health insurance plans are not required to cover hearing aids for kids, meaning only 1 in 10 families in California have some coverage. The author states that over 35 states require coverage for children’s hearing aids through commercial plans and/or the state health benefit exchange. The author argues that California should follow suit in ensuring that children are able to access hearing aids at an early stage in life. The author notes that California has tried to address this very issue through the Hearing Aids Coverage for Children Program (HACCP). HACCP was launched by the DHCS on July 1, 2021. However, according to the author, to date HACCP has only provided 225 of the 7,000 eligible youth with hearing aids through the program. Additionally, few pediatric providers are participating due to historically low reimbursement rates and high administrative burdens creating poor geographic coverage, segmented care, and barriers that are difficult to overcome. The author states that California is not alone in these challenges as Georgia tried a similar program and failed, ultimately passing an insurance mandate in 2018. The author concludes that this bill, the Let California Kids Hear Act of 2026, would mandate coverage in large group health plans to ensure that children receive timely access to pediatric hearing aids. This will, in turn, allow HACCP to focus on serving children outside the large-group health market.
- 2) BACKGROUND.** Pediatric hearing loss is a broad category that covers a wide range of pathologies. Early detection and prompt management are essential for the development of normal language and psychosocial functioning, as well as to identify potentially reversible causes or other underlying problems. Often overlooked, hearing loss is a common chronic condition and an important factor in overall health. Twenty-three percent of Americans 12 years and older have at least mild hearing loss. There are three types of hearing loss: conductive, sensorineural, and mixed. Conductive hearing loss, affecting the outer ear and middle ear, is usually transient. Sensorineural hearing loss occurs when there is damage to the inner ear hair cells or a damaged hearing nerve and is generally permanent. Most permanent hearing loss is sensorineural and is attributed to congenital causes (present at birth) or acquired during childhood. About 50% of congenital hearing loss cases are due to genetic causes, 25% of cases are due to maternal illness during pregnancy, premature birth, or complications after birth. The causes are unknown for the remaining 25% of cases. Reasons for acquired hearing loss include excessive noise, injury, certain medications, tumors, jaundice, meningitis, or problems with blood circulation. Hearing loss can range from “mild” to “profound” and can be unilateral or bilateral.

 - a) Cost of hearing aids.** Hearing aids generally cost between \$1,500 and \$4,000 per ear depending on the technology and enhancements selected by the patient. Patients also

incur costs for hearing aid-related services such as fittings, repairs, and related audiometry testing. Families with children who have hearing loss experience additional costs associated with more frequent fittings of new ear molds necessary to accommodate the child's growth (up to four times per year for infants/toddlers). According to the California Health Benefits Review Program (CHBRP), reports demonstrate that the most important challenges to parents in obtaining pediatric hearing aids are the ability to pay, accepting the need for hearing aids, and the wait time for a pediatric audiologist. A 2022 U.S. Food and Drug Administration (FDA) rule allows manufacturers to sell hearing aids over the counter without a prescription from a doctor. This increased access to hearing aids has the potential to lower prices. However, hearing aids for children is an exception to those policies. The FDA does not recommend them for children; all insurance-approved hearing devices for children are by prescription only.

b) Existing hearing aid coverage for children.

- i) Medi-Cal.** Children with family income up to 266% of the federal poverty level (FPL) are eligible for Medi-Cal. Children up to age 21 covered through Medi-Cal have coverage for hearing aids. Medi-Cal will pay up to \$1,510 per person each fiscal year (between July 1 and June 30) for hearing aid benefits, including hearing aids, except for those beneficiaries who fall under the exemptions because they are not subject to the hearing aid benefit cap. Children who are younger than age 21 and receive full-scope Medi-Cal are not subject to the hearing aid benefit cap. In addition, hearing aids that are lost, stolen, or irreparably damaged beyond the patient's control are not subject to the cap.
- ii) CCS.** Children who meet certain qualifications, including a qualifying hearing loss, have coverage for hearing aids through CCS. CCS is a state program that provides coverage for children under age 21 with certain eligible medical conditions, including hearing loss. Children may also qualify for CCS by meeting certain age, residence, medical, and financial requirements. The eligibility criteria are: the child must be under age 21; the child must be a California resident; the child has a medical condition that is covered by CCS; and, the child and family meets one of the following criteria: family state adjusted gross income of \$40,000 or less; out-of-pocket medical expenses expected to be more than 20% of family's adjusted gross income; a need for an evaluation to find out whether there is a health problem covered by CCS; the child was adopted with a known health problem that is covered by CCS; the child has a need for the Medical Therapy Program (a state program that provides services for children who have handicapping conditions, generally due to neurological or musculoskeletal disorders); or, the child is eligible for Medi-Cal, with full benefits.
- iii) HACCP.** Effective July 1, 2021, HACCP began accepting applications. The DHCS program uses an administrative vendor, MAXIMUS, to perform eligibility and ongoing case management activities for this program. HACCP covers hearing aids and related services for children under the age of 18 (age 21 beginning in 2023), who have a household income of up to 600% FPL, and who are not otherwise eligible for Medi-Cal or CCS. This is also available to individuals whose health insurance does not cover hearing aids and services. The services below are covered based on a referral from an audiologist, otolaryngologist, or physician:

- (1) Hearing aid(s) and hearing aid replacement;
- (2) Hearing aid supplies/accessories;
- (3) Hearing aid-related audiology services; and,
- (4) Other related post-evaluation services.

Based on the referral, an enrolled Medi-Cal audiologist or hearing aid dispenser will document the degree of hearing loss, medical necessity for the requested amplification method, name of the manufacturer, type of hearing aid authorized, and the number of units. The program utilizes existing Medi-Cal and CCS policies to guide the benefit structure. According to the DHCS website, as of May 2026, 1,294 program applications were received and 686 applicants were enrolled.

If this bill is approved, the Legislature's 2026-27 budget proposal assumes that HACCP would scale down due to children on large-group plans obtaining coverage for their hearing aids.

- c) **CHBRP.** CHBRP was created in response to AB 1996 (Thomson), Chapter 795, Statutes of 2002, which requests the University of California to assess legislation proposing a mandated benefit or service and prepare a written analysis with relevant data on the medical, economic, and public health impacts of proposed health plan and health insurance benefit mandate legislation. SB 125 (Hernandez), Chapter 9, Statutes of 2015, added an impact assessment on EHBs, and legislation that impacts health insurance benefit designs, cost-sharing, premiums, and other health insurance topics to CHBRP's purview. CHBRP reviewed this bill and included the following impact estimates in their analysis:
- i) **Increased utilization and premiums, lower out-of-pocket costs.** CHBRP estimates that an additional 6,926 children using hearing aids or services would be newly covered in the first year, increasing from 1,140 who had coverage. There would be an overall increase of 638 children using hearing aids, from 7,428 at baseline to 8,066 children. For some, this permits first-time use of hearing aids, and for all newly covered hearing aid users, it permits more repairs, replacements, testing, and recasted ear molds, which improve the effectiveness of the hearing aids. Premiums would increase in the large group market by \$17,320,000 across employers and enrollees, while decreasing enrollee out-of-pocket costs for noncovered benefits and cost-sharing expenses by \$12,015,000. Employer premiums would increase by \$14,228,000 (0.02%) and enrollee contributions towards premiums would increase by \$3,092,000 (0.01%).
 - ii) **Improved outcomes for children.** CHBRP notes that costs can be a barrier to accessing care more broadly, even among people with health insurance coverage. In 2022, 7.4% of Californians younger than 21 years of age delayed or did not get medical care, and over one-third (37%) of them listed cost, lack of insurance, or other insurance-related issues as the reason. Hearing aids are effective, and utilization is projected to increase under this bill. Therefore, children are expected to experience less speech problems and will have more success in school with higher measures of well-being.

d) California’s EHB benchmark plan. The United States Department of Health and Human Services (HHS) defines EHBs based on state-specific EHB benchmark plans and gives each state the authority to choose its “benchmark” plan. California chose the Kaiser Small Group HMO plan in 2012 and reviewed it in 2015. HHS issued final rules in 2018 and 2019, which provided flexibility for states by allowing new options for the EHB benchmark plan, in addition to the option of retaining the current EHB benchmark plan. In April of 2024, new rules were finalized for EHB benchmark updates through the HHS Notice of Benefit and Payment Parameters for 2025. On June 27, 2024, DMHC held a public meeting to discuss California’s EHBs and the process for updating the benchmark plan. At that meeting, DMHC shared the timeline and introduced consultants who explained the federal rules and recently approved and proposed EHB benchmark changes from other states. A second stakeholder meeting was held on January 28, 2025. At this meeting the Wakely Consulting Group (Wakely) presented an actuarial analysis that identified the benefit allowance and potential options and prices for a proposed benchmark plan. Wakely estimated the pricing of a suite of proposed benefits that potentially could be added, including hearing aids, DME, wigs, chiropractic, infertility, and adult dental. Altogether the cost of these benefits would have exceeded allowed costs, meaning choices had to be made to narrow the set of proposed benefits to be covered. A joint legislative hearing was held on February 11, 2024 to provide the Assembly and Senate Health Committees with information about the analysis and options to be considered for updating the EHB benchmark plan.

On March 28, 2025, DMHC announced California’s intent to submit a proposal to the federal government to add three new benefits to the state’s EHB benchmark plan: hearing aids, durable medical equipment, and infertility treatment. Subsequently, AB 224 (Bonta), Chapter 680, Statutes of 2025, and SB 62 (Menjivar), Chapter 739, Statutes of 2025, were passed to codify the updates to the benchmark plan, pending HHS approval. On May 5, 2025 DMHC submitted the state’s EHB update plan to the Center for Medicare & Medicaid Services (CMS). In December 2025, DMHC received a letter from CMS indicating they were pausing review of state applications to change EHB-benchmark plans and doing a comprehensive review of EHB requirements. In January, the DMHC asked CMS to reconsider and approve the state’s new benchmark plan. CMS responded that they were maintaining their current posture of pausing review of state EHB-benchmark plan update applications until further notice. In February 2026, CMS proposed rules to revise state’s responsibilities when mandating EHBs beyond the federally required package. Beginning 2027, CMS proposed that any state-required benefit would be considered “in addition to EHB” (thus not an EHB) and would require the state to defray the cost of these additional benefits for enrollees. This means the state would need to cover the costs of the three new EHB’s proposed to CMS in 2025.

3) SUPPORT. This bill is co-sponsored by Let California Kids Hear Coalition and Children Now, who state that California passed one of the nation’s first newborn hearing screening laws in 1998 in recognition that hearing loss requires early identification and intervention. Yet 28 years later, many California families are still struggling to access hearing aids for their children during critical years of brain development. The sponsors cite Children’s Hospital pediatric surgeon Dr. Daniela Carvalho who testified, “California does a beautiful job screening children, but fails miserably when it comes to treating them.” The sponsors note that today, approximately 90% of California health plans still do not cover pediatric hearing aids, telling parents that hearing is “elective” for their child. Hearing aids cost

families approximately \$6,000 per pair every three years, forcing many parents into debt, delaying treatment, or going without care altogether. The sponsors cite UCSF Hospital pediatric otolaryngologist Dr. Dylan Chan, who testified on this issue in 2019, and said, pediatric hearing loss is a “developmental emergency” for every child without access to hearing aids that is not only devastating to the child and family, but costly to society. The sponsors state that for every child with untreated hearing loss, the societal cost has been estimated at more than \$1.9 million over a lifetime when adjusted for inflation due to impacts on language development, literacy, education, employment, and long-term dependence. The sponsors continue that more than 35 states already require some level of pediatric hearing aid coverage. California remains an outlier despite overwhelming bipartisan legislative efforts spanning nearly three decades. The sponsors conclude that California should not become known as the state that identified hearing loss early, but failed to ensure children have access to sound to hear and connect with their world. This developmental emergency has been unfolding in California for years, and California cannot afford to delay action any longer.

4) PREVIOUS LEGISLATION.

- a)** AB 224 (Bonta) requires, beginning January 1, 2027, if HHS approves a new EHB benchmark plan for the State of California (state) pursuant to the submission by the state, the existing EHB benchmark plan to additionally include coverage for hearing aids, DME, and infertility benefits, as specified.
- b)** SB 62 (Menjivar) is substantially similar to AB 224.
- c)** SB 635 (Menjivar) of 2023 would have required health aid coverage for enrollees or insureds under 21 years of age. Governor Newsom vetoed SB 635, stating in part, that DHCS has developed a comprehensive plan to increase provider participation and program enrollment for HACCP.
- d)** SB 101 (Skinner), Chapter 12, Statutes of 2023, appropriated \$10,000,000 to HACCP. HACCP covers hearing aids and related services for children under the age of 21, who have a household income of up to 600% of the FPL, which is approximately \$166,000 annually for family of four, and who are not otherwise eligible for Medi-Cal or CCS, or who do not have insurance coverage, which includes a person who has health insurance coverage but not coverage for hearing aids, or, a person with health insurance coverage that covers hearing aids but with a limit of \$1,500 or less.
- e)** AB 598 (Bloom) of 2019 would have required a health plan contract or a health insurance policy issued, amended, or renewed on or after July 1, 2020, to include coverage for hearing aids, as defined, for an enrollee or insured under 18 years of age. Would have required the coverage to be performed by contracted providers, except as specified. Would have required the contracted providers to include a pediatric audiologist for children under five years of age. AB 598 was withdrawn from engrossing and enrolling.
- f)** AB 1601 (Bloom) of 2017 and AB 2004 (Bloom) of 2016 would have required coverage for hearing aids. AB 1601 was held in Assembly Appropriations Committee. AB 2004 was held in Senate Appropriations Committee.
- g)** AB 368 (Carter) of 2007 would have required 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. Governor Schwarzenegger vetoed AB 368 and indicated that “the addition of a new mandate, no matter how small, will only serve to increase the overall cost of health care and increasing the cost of coverage by mandating benefits, may ultimately leave more children without any coverage.”

- h) SB 1223 (Scott) of 2006 would have required health plans and health insurers to offer or provide, as specified, coverage up to \$1,000 for hearing aids, as defined, to all enrollees, subscribers, and insureds under 18 years of age. SB 1223 was vetoed by Governor Schwarzenegger who indicated that the bill may contribute to rising premiums and make health care less affordable and accessible for uninsured Californians.
- i) SB 174 (Scott, Koretz, and Wiggins) of 2004 would have required health plans and health insurers to provide coverage, up to \$1,000, for hearing aids, as defined, to all enrollees and subscribers under 18 years of age. SB 174 was held in Senate Rules Committee.
- j) SB 1158 (Scott) of 2004 would have required health plans and health insurers to provide coverage up to \$1,000 for hearing aids, as defined, to all enrollees, subscribers, and insureds under 18 years of age. SB 1158 was vetoed by Governor Schwarzenegger who indicated that increasing the cost of health coverage by mandating benefits, if even by a small amount, would have the far more serious consequence of leaving some children without health insurance.

REGISTERED SUPPORT / OPPOSITION:

Support

Children Now (sponsor)
 Let California Kids Hear Coalition (sponsor)
 Alexander Graham Bell Association for the Deaf and Hard of Hearing
 American Academy of Pediatrics, California
 Association of Regional Center Agencies
 California Children's Hospital Assn
 California Hands & Voices
 California Medical Association (CMA)
 California School-based Health Alliance
 CCHAT Center
 Center for Early Intervention on Deafness
 Children's Hospital Los Angeles
 Children's Specialty Care Coalition
 Disability Rights California
 Family Voices of California
 First 5 Orange County
 First 5 San Mateo County
 Foundation for Hearing Research, dba Weingarten Children's Center
 Health Access California
 Healthier Kids Foundation
 HearAid Foundation
 John Tracy Clinic
 National Health Law Program

No Limits for Deaf Children
Pacific Neuroscience Institute
Rady Children's Hospital
UCSF Benioff Children's Hospital Oakland Audiology
Several individuals

Opposition

None on file

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