SENATE THIRD READING
SB 331 (Menjivar)
As Amended August 19, 2026
Majority vote

SUMMARY

Requires, *commencing January 1, 2028***,** a large group health plan or health insurer to cover medically necessary hearing aids *and related services* for kids under 21 years of age. *Authorizes the health plan or insurer to limit coverage for each individual hearing aid device to $3,000. Prohibits a health plan or insurer from subjecting hearing aids covered pursuant to this bill to a deductible and caps coinsurance to 10%.*

Major Provisions

COMMENTS

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.

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.

Existing hearing aid coverage for children.

1) *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.

2) *California Children's Services (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.

3) *Hearing Aid Coverage for Children Program (HACCP).* Effective July 1, 2021, HACCP began accepting applications. The Department of Health Care Services (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:

   a) Hearing aid(s) and hearing aid replacement;

   b) Hearing aid supplies/accessories;

   c) Hearing aid-related audiology services; and,

   d) 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.

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 essential health benefits (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:

1) *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%).

2) *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.

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, the Department of Managed Health Care (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, durable medical equipment, 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, 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.

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.

Arguments in 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.

Arguments in Opposition
None on file.

FISCAL COMMENTS

According to the Assembly Appropriations Committee:

1) Minor and absorbable costs to DMHC and the Department of Insurance (CDI).

2) CHBRP and the California Public Employees Retirement System (CalPERS) anticipate zero to minimal effect on premiums for DMHC-regulated health plans in CalPERS. Effects on premiums for CDI-regulated insurance policies would likely also be negligible.

3) CHBRP estimates this bill will increase premiums in the state-regulated large group market by $17.3 million across all employers ($14.2 million or 0.02%) and enrollees ($3.1 million or 0.01%), while decreasing enrollee out-of-pocket costs by $12.0 million. These costs are not borne by the state.

VOTES

SENATE FLOOR: 27-0-13
YES: Allen, Archuleta, Arreguín, Becker, Blakespear, Caballero, Cervantes, Cortese, Durazo, Gonzalez, Grayson, Grove, Hurtado, Laird, Limón, McGuire, McNerney, Menjivar, Padilla, Pérez, Richardson, Rubio, Smallwood-Cuevas, Stern, Umberg, Wahab, Wiener
ABS, ABST OR NV: Alvarado-Gil, Ashby, Cabaldon, Choi, Dahle, Jones, Niello, Ochoa Bogh, Reyes, Seyarto, Strickland, Valladares, Weber Pierson

ASM HEALTH: 14-0-2
YES: Bonta, Sanchez, Addis, Aguiar-Curry, Ahrens, Caloza, Jeff Gonzalez, Mark González, Patel, Patterson, Celeste Rodriguez, Schiavo, Sharp-Collins, Stefani
ABS, ABST OR NV: Carrillo, Johnson

ASM APPROPRIATIONS: 15-0-0
YES: Wicks, Hoover, Arambula, Calderon, Caloza, Dixon, Fong, Mark González, Krell, Pacheco, Pellerin, Sharp-Collins, Solache, Ta, Tangipa

UPDATED

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