



June 23, 2026

The Honorable Mia Bonta
Chair, Assembly Health Committee
1020 N Street, Room 390
Sacramento, CA 95814

The Honorable Caroline Menjivar
Chair, Senate Health Committee
1021 O Street, Room 6630
Sacramento, CA 95814

The Honorable Sabrina Cervantes
Chair, Senate Appropriations Committee
1021 O Street, Suite 7620
Sacramento, CA 95814

The Honorable Buffy Wicks
Chair, Assembly Appropriations Committee
1021 O Street, Suite 8140
Sacramento, CA 95814

Re: Requested Letter to the 2025-26 California State Legislature on Senate Bill 331: Hearing Aids as Amended on June 1, 2026

Dear Chairs Bonta, Menjivar, Cervantes, and Wicks:

The California Health Benefits Review Program (CHBRP) was asked by the Assembly Committee on Health to provide an update regarding Senate Bill (SB) 331, Hearing Aids (as amended on June 1, 2026). CHBRP submitted [an analysis](#) of a related bill in June of 2023.¹ This letter provides a high-level recap of CHBRP's key findings on this topic, and it provides an updated fiscal estimate based on the June 1st amendments. Appendix A contains detailed revised benefit coverage, utilization, and cost estimates and tables.

CHBRP was able to access up-to-date claims files to assess utilization in commercial populations in other states that have recently enacted mandated coverage for hearing aids for children. Specifically, CHBRP looked closely at Texas and Massachusetts. This examination of claims data found somewhat higher utilization of newly covered hearing aids and related services for children than CHBRP previously projected. CHBRP also found that the unit prices of hearing aids have decreased since 2023, offsetting some of the fiscal impact of higher projected utilization, were the proposed benefit mandate enacted.

Context

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 (Dimitrov and Gossman, 2023). 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 (Goman and Lin, 2016).

Types of 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 (CDC, 2015a). Sensorineural hearing loss

¹ In addition, CHBRP has analyzed other versions of this proposed health insurance benefit mandate, dating as far back as 2003.

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 (CDC, 2015b). Reasons for acquired hearing loss include excessive noise, injury, certain medications, tumors, jaundice, meningitis, or problems with blood circulation (Boyle et al., 2011; Shargorodsky et al., 2010).

Hearing loss can range from “mild” to “profound” and can be unilateral or bilateral (one or both ears).

Types and Costs of Hearing Aids

Costs and Ability to Pay

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 with 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/toddlers²). Muñoz et al. (2013) reported that the most important challenges to parents in obtaining pediatric hearing aids were the ability to pay, accepting the need for hearing aids, and the wait time for a pediatric audiologist.

Over-the-counter hearing aids

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 (FDA, 2022). 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 (FDA, 2023).

Bill Language

As amended on June 1, 2026, SB 331 would require large group plans and policies regulated by the California Department of Managed Health Care (DMHC) and California Department of Insurance (CDI) to include coverage for hearing aids³ for enrollees under 21 years of age, if medically necessary, on or after January 1, 2027.

The bill stipulates that covered services shall be provided by a contracted provider, unless the contract allows for out-of-network coverage. For children under five years of age, a contracted provider shall include a pediatric audiologist.

Coverage under SB 331 would include an initial assessment, new hearing aids at least every 3 years, new ear molds, new hearing aids if alterations to existing hearing aids cannot meet the needs of the child, a new hearing aid if the existing one no longer functions, and adjustments, auditory training, and maintenance of the hearing aids.

The bill language would impose an annual coverage cap of \$3,000 per individual hearing aid, and prohibit any cost sharing (deductible, coinsurance, or copayment).

² Personal communication, M. Winter, March 2016.

³ Hearing aids are defined in the bill as “an electronic device usually worn in or behind the ear of a deaf and hard of hearing person for the purpose of amplifying sound.”

Relevant Populations

If enacted, this proposed mandate would apply to the health insurance of approximately 8,244,000 enrollees (21.6% of all Californians) in 2027. This represents 36% of the 22.8 million Californians who have health insurance regulated by the California Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI).

Evidence of Effectiveness

In its 2019 analysis of Assembly Bill (AB) 598, CHBRP concluded that a preponderance of evidence (strong evidence) from studies with moderately strong research designs supports the following findings (CHBRP, 2019):

- Hearing aids are effective in improving speech outcomes in children. Evidence suggests that earlier fitting with hearing aids is associated with greater gains in speech outcomes.
- Hearing aids are effective in improving language development outcomes in children. The risk of language delays among children with hearing loss may be mitigated by early fitting and consistent use of hearing aids.

Conversely, there is insufficient evidence (not enough research to determine) that hearing aids are effective in improving nonverbal outcomes (e.g., motor behavior) in children. There is conflicting evidence that hearing aids are effective in improving personal and social development outcomes in children. CHBRP did not complete a new Medical Effectiveness analysis for SB 331 given the compressed timeline provided to complete this analysis.

Interaction With Existing State and Federal Requirements

Health benefit mandates may interact and align with the following state and federal mandates or provisions.

California Policy Landscape

California law and regulations

California law requires screening for hearing loss among children, first at birth in the Newborn Hearing Screening Program and subsequently at school age (for students in the public school system) (NCSL, 2011).^{4,5,6}

For children aged 21 years and under in Medi-Cal and children who meet certain qualifications,⁷ including a qualifying hearing loss, hearing aids are covered through California Children's Services (CCS). CCS is a state program that provides coverage for children with certain eligible medical conditions, including hearing loss. Children may also qualify for CCS by meeting certain age, residence, medical, and financial requirements.^{8,9} Having commercial insurance does not preclude a child from receiving services through CCS. If they meet one or more of the previously mentioned requirements, children with commercial

⁴ Cal. Health and Safety Code § 123975.

⁵ Cal. Health and Safety Code § 124115 et seq.

⁶ California Code of Regulations, Title 17, Section 2952 (c)(1).

⁷ Some privately insured children are eligible based on household income guidelines, currently up to 600% of FPL.

⁸ Medi-Cal Provider Manual. Part 2 – Audiology and Hearing Aids (AUD), California Children's Services (CCS) Program.

⁹ <http://www.dhcs.ca.gov/services/ccs/Pages/qualify.aspx>.

insurance may receive coverage through CCS for certain conditions (e.g., hearing loss) that their insurance does not cover.¹⁰

The Budget Act of 2020 (Assembly Bill 89, Chapter 7, Statutes of 2020) authorized the Hearing Aid Coverage for Children Program (HACCP), which launched on July 1, 2021. This program serves California children who are not eligible for Medi-Cal and/or hearing-related coverage through CCS and live in a household with income up to 600% of the federal poverty level (FPL).¹¹ HACCP was initially available to children under 18 without insurance or whose insurance does not cover hearing aids and related services. Effective January 1, 2023, the Budget Act of 2022 (Assembly Bill 179, Chapter 249, Statutes of 2022) expanded the age criteria for HACCP to children under the age of 21, and broadened coverage to children who had other insurance with coverage of \$1,500 per year or less for hearing aids.

Other States

Nationwide, 35 states require hearing aid coverage for children in 2026 (private or exchange coverage). 30 states require state-regulated private individual and group insurance plans to cover children's hearing aids, 29 states include hearing aids in their state essential health benefits (EHBs), and 24 states cover children's hearing aids in both markets.^{12,13}

Federal Policy Landscape

Medicare is the federal health insurance program for older U.S. adults that offers coverage once a person turns 65 (beneficiaries may also qualify if they have permanent kidney failure or receive disability benefits). Original Medicare (also known as Parts A and B, or the public portion of Medicare) does not cover most routine hearing care or the cost of hearing aids. However, Medicare Advantage plans (Part C) generally provide some coverage for the cost of hearing aids. Legislation to expand coverage for hearing aids has been proposed in recent years but has not yet been passed.

Analytic Approach

CHBRP has drawn from its prior analyses of SB 635 (2023), AB 598 (2019), and AB 2004 (2016) to inform this analysis and at the request of the Committee has provided updated fiscal estimates.

Based on the definition in the bill language, this analysis examines the use of conventional hearing aids and the nonsurgically implanted, wearable bone conduction hearing aids (BCHA). This analysis did not include cochlear implants.

In this updated analysis, only state-regulated large group and CalPERS health maintenance organization (HMO) populations, premiums, and cost sharing are included and modeled; impacts to the individual and small-group markets or Medi-Cal are not shown given that they are not subject to SB 331 as amended on June 1, 2026. The population, premiums, and cost sharing impacts shown in this letter have been updated to use 2027 population and premium estimates that were projected using CHBRP's 2026 California Coverage and Cost Model.

¹⁰ Personal communication with Margaret Winter, March 15, 2016.

¹¹ Children can qualify for HACCP regardless of immigration status.

¹² States have adopted a variety of age limits, financial caps, and frequency restrictions: some states limit pediatric benefits to age 18 and under, while others extend coverage through age 21. Coverage structures range from specific cash caps (e.g., \$1,000 to \$3,000 per year) to treating devices under standard deductible and co-pay rules. Most states restrict coverage to one new device per ear every 24 to 48 months.

¹³ Source: <https://letcakidshhear.com/facts/state-details/>.

Updates in Expenditure Impacts

Given the necessity of hearing aids for children who need them, parents and guardians may find a way to obtain hearing aids even without insurance coverage. Some evidence suggests that hearing aids are largely price inelastic; in other words, the purchase and use of hearing aids may be largely unaffected by price.

- CHBRP estimates that the removal of a cost barrier when coverage is introduced for hearing aids would result in an increase in utilization of 10% among enrollees who *do not have* coverage for hearing aids and services postmandate.¹⁴
- CHBRP estimates no change in utilization among the population with baseline coverage.
- The combined rate of utilization for the total population of enrollees aged 0 to 20 years postmandate is estimated at 0.3%. This reflects the utilization increase that occurs for enrollees who were not covered at baseline and would have coverage postmandate as well as increased utilization due to a reduction in cost sharing.

CHBRP estimates that an additional 6,926 children using hearing aids or services would be newly covered in the first year. There would be an overall increase of 638 children using hearing aids, from 7,428 at baseline to 8,066 postmandate. Of the 7,428 children using hearing aids at baseline, 1,140 had coverage. 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. All of these newly covered children would be in commercial health insurance plans or policies since CalPERS currently covers hearing aids and services.

Postmandate, CHBRP estimates hearing aids and services cost on average \$2,205 per user per year, which includes children who may not have purchased a new hearing aid in the given year, but may use related hearing aid services in that year.

CHBRP estimates that SB 331, as amended on June 1, 2026, would increase premiums for the state-regulated 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. In the large group market, employer premiums would increase by \$14,228,000 (0.02%) and enrollee contributions towards premiums would increase by \$3,092,000 (0.01%).

Overall, this estimate is lower than CHBRP's previous estimated fiscal impact. The prior version of the bill applied to all DMHC-regulated plans and CDI-regulated policies, while SB 331 applies to plans and policies in the large group market and CalPERS subject to state regulation. See Appendix A of this letter for additional details on the utilization and expenditure estimates of SB 331 as amended on June 1, 2026.

Public Health Impacts

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 (CHIS, 2022). The cost of health insurance for covered workers has continued to increase, with the average premium for family coverage in employer sponsored plans increasing by 26% over the last five years (KFF, 2025).

¹⁴ For more in-depth explanation of data sources and assumptions, please see Appendix B of this Letter.
Current as of June 23, 2026

Hearing aids are effective, and utilization is projected to increase under SB 331. Therefore, children are expected to experience less speech problems and will have more success in school with higher measures of well-being.

Closing Comments

CHBRP finds that SB 331, as amended, would increase utilization of services in large group and CalPERS plans and policies subject to state regulation, consistent with the prior analyses. However, based on newly available claims from other states (Texas and Massachusetts, specifically), CHBRP has adjusted the level of demand expected by SB 331 were it enacted.

To the extent that increased utilization results in improved health outcomes, there would be a public health impact within the large group market subject to state regulation.

CHBRP's faculty and staff appreciate the opportunity to provide this analysis, and we will be happy to respond to any of your questions.

Sincerely,

A handwritten signature in blue ink, appearing to read "Garen L. Corbett".

Garen L. Corbett, MS
Director, California Health Benefits Review Program

Appendix A. Benefit Coverage and Cost Impacts

This appendix provides details related to the fiscal analysis of SB 331 as amended on June 1, 2026.

Benefit Coverage

If enacted, this proposed mandate would apply to the health insurance of approximately 8,244,000 enrollees (21.6% of all Californians). This represents 36% of the 22.8 million Californians who have health insurance regulated by the California Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI).

As shown in Table 1 below, CHBRP estimates that 14% of the large group market has coverage for pediatric hearing aids at baseline. Postmandate, CHBRP estimates 8,244,000 Californians would have coverage compliant with SB 331.

Table 1. SB 331 Impacts on Benefit Coverage, 2027

	Baseline	Postmandate	Increase/Decrease	Percentage Change
Total enrollees with health insurance subject to state benefit mandates (a)	22,842,000	22,842,000	0	0.00%
Total enrollees with health insurance subject to SB 331	8,244,000	8,244,000	0	0.00%
Percentage of enrollees with coverage for mandated benefit	14%	100%	86%	602.13%
Number of enrollees with fully compliant coverage for mandated benefit	1,174,137	8,244,000	7,069,863	602.13%

Source: California Health Benefits Review Program, 2026.

Note: (a) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.

Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; DMHC = Department of Managed Health Care.

Baseline Utilization

CHBRP estimates there are 7,428 users of hearing aids and/or services aged 0 to 20 years at baseline, including about 1,140 who have coverage for these services and 6,288 who do not have coverage. Among all users, enrollees would use 4,763 hearing aids including replacements, 8,449 services for maintenance and repair, 4,650 services for ear molds, and 2,211 diagnostic tests, hearing aid checks, fittings and adjustments (screening that is not initial assessment) within a 1-year period at baseline.

Table 2. SB 331 Impacts on Utilization and Unit, 2027

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Total enrollees aged 0-20 years subject to SB 331 using hearing aids and/or related services	7,428	8,066	638	8.58%
Hearing aid and services for enrollees aged 0-20 with hearing aid coverage (number of services)				
Hearing aids	731	5,172	4,441	607.47%
Hearing aid maintenance & repair	1,297	9,174	7,877	607.47%
Ear molds	714	5,049	4,335	607.47%
Diagnostic test, hearing aid checks, fittings and adjustments	339	2,401	2,062	607.47%
Hearing aid and services for enrollees aged 0-20 with no hearing aid coverage (number of services)				
Hearing aids	4,032	0	(4,032)	-100.00%
Hearing aid maintenance & repair	7,152	0	(7,152)	-100.00%
Ear molds	3,936	0	(3,936)	-100.00%
Diagnostic test, hearing aid checks, fittings and adjustments	1,872	0	(1,872)	-100.00%
Average cost per user				
Hearing aid and/or services average cost per user	\$1,910.64	\$2,204.85	\$294.21	15.40%

Source: California Health Benefits Review Program, 2026.

Postmandate Utilization

As discussed above, CHBRP estimates that 638 additional children would use hearing aids postmandate which reflects an increase in utilization of 10% among users with no coverage at baseline. For enrollees aged 0 to 20 years using hearing aids and subject to the proposed mandate, CHBRP estimates that overall utilization would increase by 8.6% during the first 12 months after the mandate takes effect.

Postmandate, CHBRP estimates 409 additional hearing aids including replacements, 725 additional services for maintenance and repair, 399 services for ear molds, and 190 diagnostic tests, hearing aid checks, fittings and adjustments (screening that is not initial assessment) over a 1-year period. Details on the approach for baseline and postmandate utilization are available in Appendix B.

Baseline and Postmandate Unit Cost

Based on 2024 commercial claims data, CHBRP estimates hearing aids and/or services cost on average \$1,911 per user per year (2027 cost). This cost is the average annual cost per user and may include two hearing aids for children with bilateral hearing loss. This average cost per user of hearing aids and/or services includes all types of users, including those who receive hearing aids and those who may receive hearing services (e.g., diagnostic tests) but not hearing aids.

CHBRP estimates the postmandate average cost of hearing aids would increase. Commercial enrollees with new coverage would likely opt for more expensive devices because of the elimination of cost sharing and out-of-pocket costs up to the permitted \$3,000 benefit maximum per hearing aid. Postmandate, the average annual cost per user per year is estimated to rise to \$2,205. While the proposed mandate would not increase the unit cost of the specific devices or services themselves, CHBRP expects the selected types of devices and services to change.

Premiums and Expenditures

Postmandate, SB 331 would result in increases in total premiums paid by employers and enrollees of DMHC-regulated plans and CDI-regulated policies. CHBRP estimates that SB 331, as amended on June 1, 2026, would increase premiums for the state-regulated large group market by \$17,320,000 across employers and enrollees, while decreasing enrollee out-of-pocket costs for noncovered benefits by \$12,015,000. In the large group market, employer premiums would increase by \$14,228,000 (0.02%) and enrollee contributions towards premiums would increase by \$3,092,000 (0.01%).

There are no projected impacts to CalPERS or Medi-Cal.

Table 3. SB 331 Impacts on Premiums, 2027

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Non-enrollee Premiums				
Employer-sponsored (a)	\$75,730,916,000	\$75,745,144,000	\$14,228,000	0.02%
CalPERS employer (b)	\$8,611,855,000	\$8,611,855,000	\$0	0.00%
Medi-Cal (c)	\$42,982,384,000	\$42,982,384,000	\$0	0.00%
Enrollee Premiums				
Enrollees, individually purchased insurance	\$25,775,325,000	\$25,775,325,000	\$0	0.00%
Outside Covered California	\$9,551,761,000	\$9,551,761,000	\$0	0.00%
Through Covered California	\$16,223,564,000	\$16,223,564,000	\$0	0.00%
Enrollees, group insurance (d)	\$21,828,135,000	\$21,831,227,000	\$3,092,000	0.01%
Total Premiums	\$174,928,615,000	\$174,945,935,000	\$17,320,000	0.01%

Source: California Health Benefits Review Program, 2026.

Current as of June 23, 2026

Notes: (a) In some cases, a union or other organization. Excludes CalPERS.

(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 49.0% are state retirees, state employees, or their dependents.

(c) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

(d) Enrollee premium expenditures include contributions by enrollees to employer (or union or other organization)-sponsored health insurance, health insurance purchased through Covered California, and any contributions to enrollment through Medi-Cal to a DMHC-regulated plan.

Enrollee Expenses

SB 331 would increase benefit coverage and prohibit cost sharing in the form of deductibles, coinsurance, and copays for hearing aids while permitting a benefit cap of \$3,000 per hearing aid. As a result, enrollees who were paying for hearing aids out of pocket at baseline would have coverage for hearing aids without cost sharing postmandate (if their hearing aids were below the benefit cap). Similarly, enrollees with coverage at baseline would see their cost sharing eliminated (if their hearing aids were below the benefit cap). Most of the reduced out-of-pocket costs are driven by newly covered hearing aids rather than reduced cost sharing for those with coverage at baseline.

Enrollees with hearing aids that exceed the benefit cap would still see out-of-pocket costs postmandate. Furthermore, some enrollees may continue to incur direct costs which would not be covered by insurance. For example, if a hearing aid is lost or damaged before it is eligible for a new device (three years), enrollees may pay for the replacement cost of the device. Alternatively, enrollees may pay a device-specific deductible under a manufacturer warranty program operating outside of health insurance.

Table 4. Baseline Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2027

	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Policies (by Market) (a)			Total
	Large Group	Small Group	Individual	CalPERS (b)	Medi-Cal (c)		Large Group	Small Group	Individual	
					Under 65	65+				
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	7,929,000	2,097,000	2,444,000	931,000	8,078,000	965,000	315,000	42,000	41,000	22,842,000
Total enrollees in plans/policies subject to SB 331	7,929,000	0	0	0	0	0	315,000	0	0	8,244,000
Premium costs										
Average portion of premium paid by employer (e)	\$619.33	\$539.05	\$0.00	\$770.84	\$367.89	\$632.17	\$780.34	\$573.31	\$0.00	\$127,325,155,000
Average portion of premium paid by enrollee	\$134.02	\$263.52	\$864.90	\$145.41	\$0.00	\$0.00	\$184.88	\$242.16	\$832.16	\$47,603,460,000
Total premium	\$753.35	\$802.56	\$864.90	\$916.25	\$367.89	\$632.17	\$965.22	\$815.47	\$832.16	\$174,928,616,000
Enrollee expenses										
Cost sharing for covered benefits (deductibles, copays, etc.)	\$56.38	\$184.07	\$271.63	\$70.59	\$0.00	\$0.00	\$126.72	\$213.52	\$192.93	\$19,432,815,000
Expenses for noncovered benefits (f)	\$0.12	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.14	\$0.00	\$0.00	\$12,015,000
Total expenditures	\$809.85	\$986.63	\$1,136.53	\$986.84	\$367.89	\$632.17	\$1,092.08	\$1,029.00	\$1,025.09	\$194,373,446,000

Source: California Health Benefits Review Program, 2026.

Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).

(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 49.0% are state retirees, state employees, or their dependents.

(c) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans. Includes those who are also Medicare beneficiaries.

(d) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.¹⁵

(e) In some cases, a union or other organization – or Medi-Cal for its beneficiaries.

(f) Includes only those expenses that are paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.

Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; DMHC = Department of Managed Health Care.

¹⁵ For more detail, see CHBRP's [Resource, Sources of Health Insurance in California](#), 2027.

Table 5. Postmandate Change in Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2027

	DMHC-Regulated						CDI-Regulated			Total
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Policies (by Market) (a)			
	Large Group	Small Group	Individual	CalPERS (b)	Medi-Cal (c)		Large Group	Small Group	Individual	
				Under 65	65+					
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	7,929,000	2,097,000	2,444,000	931,000	8,078,000	965,000	315,000	42,000	41,000	22,842,000
Total enrollees in plans/policies subject to SB 331	7,929,000	0	0	0	0	0	315,000	0	0	8,244,000
Premium costs (postmandate change)										
Average portion of premium paid by employer (e)	\$0.1431	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.1627	\$0.0000	\$0.0000	\$14,228,000
Average portion of premium paid by enrollee	\$0.0310	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0386	\$0.0000	\$0.0000	\$3,091,000
Total premium	\$0.1740	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.2013	\$0.0000	\$0.0000	\$17,319,000
Enrollee expenses (postmandate change)										
Cost sharing for covered benefits (deductibles, copays, etc.)	-\$0.0014	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	-\$0.0003	\$0.0000	\$0.0000	-\$132,000
Expenses for noncovered benefits (f)	-\$0.1208	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	-\$0.1389	\$0.0000	\$0.0000	-\$12,015,000
Total expenditures	\$0.0519	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0621	\$0.0000	\$0.0000	\$5,172,000
Postmandate percent change										
% change insured premiums	0.0231%	0.0000%	0.0000%	0.0000%	0.0000%	0.0000%	0.0209%	0.0000%	0.0000%	0.0099%
% change total expenditures	0.0064%	0.0000%	0.0000%	0.0000%	0.0000%	0.0000%	0.0057%	0.0000%	0.0000%	0.0027%

Source: California Health Benefits Review Program, 2026.

Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).

(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 49.0% are state retirees, state employees, or their dependents.

(c) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans. Includes those who are also Medicare beneficiaries.

(d) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.¹⁶

(e) In some cases, a union or other organization, or Medi-Cal for its beneficiaries.

(f) Includes only those expenses that are paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.

Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; DMHC = Department of Managed Health Care.

¹⁶ For more detail, see CHBRP's [Resource Sources of Health Insurance in California](#) for 2027.

Appendix B. Analysis Specific Assumptions and Data Sources

This subsection discusses the caveats and assumptions relevant to an analysis of the Proposed Pediatric Hearing Aids Coverage Benefit Mandate (proposed mandate).

- The population subject to the mandated offering includes children covered by large group DMHC-regulated commercial insurance plans and CDI-regulated policies. CalPERS and Medi-Cal currently offer coverage for hearing aids and are thus already compliant with the coverage component of the proposed mandate.
- Because this mandate does not affect the individual or small group markets, the proposed mandate has no impact on Essential Health Benefits (EHBs).
- Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes related to hearing aids including replacements, codes related to screening and diagnostics, hearing aid fittings, ear molds, and maintenance and repairs, were identified with CHBRP's content expert. Below is the list of HCPCS and CPT codes categorized under each group:
 - Hearing Aid: 69714, 69799, L8690, L8691, L8692, L8693, V5030, V5050, V5060, V5080, V5090, V5110, V5130, V5140, V5160, V5180, V5220, V5241, V5246, V5253, V5254, V5255, V5256, V5257, V5258, V5259, V5260, V5261, V5267, V5298, V8692
 - Maintenance and Repair: 69711, L7510, L7520, V5014, V5299
 - Ear Molds: V5264, V5265, V5275
 - Assessment and auditory training: 92590, 92591, 92592, 92593, 92594, 92595, V5010, V5011, V5020, 92630, 92633

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- The following hearing aid codes were excluded as they identify services not covered by the proposed mandate: codes relating to cochlear implants, codes relating to battery and cord replacements, and codes associated with auditory screening other than hearing-aid assessments and thus already covered under California's EHBs.
- The final claims database used was limited to children aged 0 to 20 years identical to the bill language. CHBRP summarized four categories of hearing aid services within the claims data and thus reports utilization by these categories in Table 1: Hearing aids including replacements; Hearing aid maintenance and repair; Ear molds; and Diagnostic assessments, fittings, and adjustments.
- The identified HCPCS and CPT codes were used to extract data from Milliman's 2024 Consolidated Health Cost Guidelines Sources Database (CHSD). These data were used to develop baseline cost and utilization information for hearing aids. Baseline cost and utilization rates per 1,000 members were calculated and used to estimate enrollee counts for each service type and cost per user.
- Postmandate, enrollees may continue to incur direct costs which would not be covered by insurance. For example, if a hearing aid is lost or damaged before it is eligible for a new device (three years), enrollees may pay for the replacement cost of the device. Alternatively, enrollees may pay a device-specific deductible under a manufacturer warranty program operating outside of

health insurance. The cost of hearing aids and services does not include any additional costs from warranties or accessories that might be purchased by families obtaining hearing aids for children to protect hearing aids.

- Baseline cost was trended at a 4.5% annual rate of increase from 2024 to 2027 based on typical trends for professional services in the 2025 Milliman Health Cost Guidelines, for a total increase in cost of 14.1% over the time period.
- Baseline utilization was trended at a 1.0% annual rate of increase from 2024 to 2027 based on average trends for professional services in the 2025 Milliman Health Cost Guidelines, for a total increase in utilization of 3.0% over the time period.
- Carrier surveys from a prior bill analysis for SB 635 (2023) were used to estimate the typical cost-sharing for large group plans.
- The average cost sharing post-mandate was assumed to be the difference between the cost of the hearing aid and the \$3,000 as stipulated by SB 331.
 - The average cost of hearing aids was below \$3,000 in most cases.
 - CHBRP assumed that 5% of hearing aids would cost \$6,000 and therefore the enrollee cost sharing would be \$3,000. CHBRP assumed that enrollee cost sharing was \$0 on all other hearing aids.
- Consistent with the bill's 'per individual hearing aid' language, we assumed the \$3,000 maximum coverage amount applies per device. As such, an enrollee requiring bilateral hearing aids would be eligible for up to \$6,000 in total coverage for hearing aids.
- Coverage assumptions from SB 635 (2023) were used to estimate the percentage of enrollees who have hearing aid coverage pre-mandate.
- To estimate the total number of services provided, CHBRP estimated the percentage of children with coverage for hearing aids in the 2024 claims database, based on responses to the carrier surveys for the analysis of similar bills introduced in 2016 (AB 2004), 2017 (SB 1601), and 2023 (SB 635). The surveys revealed that 14% of commercially insured large group enrollees have this coverage.
- CHBRP then calculated the utilization rate as a percentage of enrollees; the analysis showed that 0.05% of children received at least one of the relevant hearing aid services. For each of the service types, CHBRP calculated a similar value. CHBRP then applied the utilization rates to each of the population cohorts that currently have coverage.
- CHBRP assumed an induced utilization of 10% for pediatric hearing aids, meaning that full coverage would result in 10% more services than without coverage.
 - CHBRP was unable to find any literature on induced utilization directly relevant to pediatric hearing aids; however, CHBRP reviewed utilization data in states with full coverage for pediatric hearing aids in Massachusetts and Texas.
 - Several sources¹⁷ indicate that demand for hearing aids is relatively inelastic, indicating that reimbursement level is not a significant deterrent for hearing aid usage. Note that there is evidence to suggest that even in the absence of coverage, demand is very inelastic due to charity care and research on pediatric services as well as services for those with disabilities.
 - CHBRP's content expert on a prior bill (AB 598 (2019)) pointed out that there are a number of ways families might receive help for obtaining hearing aids if cost

¹⁷ <https://www.audiologyonline.com/articles/20q-audiology-economics-28543>

poses a barrier. For currently noncovered enrollees who meet certain financial qualifications, they can receive financial aid and full coverage for hearing aids. California Children's Services (CCS) is available for hearing aid services for children who are commercially insured but do not have a hearing aid benefit or have high out-of-pocket costs for hearing aids depending on their financial status. There are other charitable organizations that provide hearing aids for free or at a drastic discount, based on specified financial qualifications. For example, the Miracle-Ear Children's Foundation provides hearing aids to children 18 years or younger whose families are low income but do not qualify for public support (Miracle-Ear Children's Foundation, 2016). Utilization rates and cost data for enrollees obtaining hearing aids through CCS, charitable organizations, or for those purchasing units fully out of pocket, are not available and thus not included in this analysis. Individuals who pay out of pocket might replace their hearing aids less frequently than those who have a covered benefit. We did not model this.

- Goldman and Grossman (1978) find the price elasticity of demand for pediatric visits to be -0.03 to -0.06 . Similarly, Wolfson et al. (1982) found no relationship between user fees/cost-sharing and the use of services among disabled children, suggesting the presence of a disability makes it less likely to reduce the use of medical services and parents are likely less inclined to risk the child's health by foregoing medical services.
- Other studies suggest the potential for high induced utilization. For participants of the Military Health System, a recent study¹⁸ published in January 2025 stated that the hearing aid utilization rate was 78% for full-covered populations with acute hearing loss and 49% for populations with no coverage and acute hearing loss. This suggests a potential induced utilization rate of up to 60%.
- Some enrollees who are subject to lower benefits or higher cost-sharing requirements and currently purchase lower-cost devices are expected to purchase higher-cost devices post-mandate. For Commercial members, CHBRP estimates the average price of hearing aids will increase by approximately 15.4% post-mandate, and average cost sharing will decrease by 21.4%.
- Health plans and insurers often provide discounts to members or subscribers. Even if health plans and insurers do not cover hearing aids, it is common for many to have relationships with vendors to provide a discount to their members or subscribers. These relationships may change postmandate; however, due to the uncertainty in how the mandate would shift provider-vendor relationships, CHBRP is unable to estimate impacts of these changes.

¹⁸ <https://onlinelibrary.wiley.com/doi/abs/10.1002/lary.32013>.

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