WEST VIRGINIA LEGISLATURE

2026 REGULAR SESSION

Introduced

House Bill 5433

By Delegates Bell, Campbell, Amos, Ellington, and Heckert

[Introduced February 11, 2026; referred to the Committee on Finance]

A BILL to amend the Code of West Virginia, 1931, as amended, by adding six new sections, designated §5-16-7h, §33-15-4y, §33-16-3aaa, §33-24-7z, §33-25-8w and §33-25A-8z, all relating generally to requiring health insurance coverage of hearing aids.

Be it enacted by the Legislature of West Virginia:

CHAPTER 5. GENERAL POWERS AND AUTHORITY OF THE GOVERNOR, SECRETARY OF STATE AND ATTORNEY GENERAL; BOARD OF PUBLIC WORKS; MISCELLANEOUS AGENCIES, COMMISSIONS, OFFICES, PROGRAMS, ETC.

ARTICLE 16. WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE ACT.

§5-16-7h. Required coverage for hearing aids.

(a) A policy, plan, or contract that is issued or renewed on or after January 1, 2026, shall provide coverage for the cost of hearing aids that are prescribed by a licensed physician for individuals covered under the policy or plan. The policy or plan shall at a minimum provide coverage for:

(1) Initial hearing aids and replacement hearing aids at least as frequently as every 36 months;

(2) New hearing aids when alterations to the existing hearing aids cannot adequately meet the needs of the covered individual;

(3) Services, including audiometric testing, hearing aid evaluations, fittings and adjustments; and

(4) At least one annual audiological evaluation.

(b) For purposes of this section, “hearing aid” means any wearable device or instrument or any combination thereof, designated for, represented as or offered for sale for the purpose of aiding, improving or compensating for defective or impaired human hearing and includes ear

molds, parts, attachments or other medically necessary accessories, but excludes batteries and cords.

(c) The same deductibles, coinsurance, network restrictions and other limitations for covered services found in the policy, provision, contract, plan or agreement of the covered individuals apply to hearing aids covered pursuant to this section. Required coverage is further limited to the cost of one hearing aid including all covered hearing aid-related services not to exceed an aggregate of $1,400 per hearing-impaired ear every 36 months. The insured may choose a higher priced hearing aid and may pay the difference in cost above the $1,400 limit as provided in this section without any financial or contractual penalty to the insured or to the provider of the hearing aid.

(d) To the extent that the provisions of this section require benefits that exceed the essential health benefits specified under section 1302(b) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, the specific benefits that exceed the specified essential health benefits are not required of a health benefit plan when the plan is offered by a health care insurer in this state.

CHAPTER33. INSURANCE.

ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.

§33-15-4y. Required coverage for hearing aids

(a) A policy, plan, or contract that is issued or renewed on or after January 1, 2026, shall provide coverage for the cost of hearing aids that are prescribed by a licensed physician for individuals covered under the policy or plan. The policy or plan shall at a minimum provide coverage for:

(1) Initial hearing aids and replacement hearing aids at least as frequently as every 36 months;

(2) New hearing aids when alterations to the existing hearing aids cannot adequately meet the needs of the covered individual;

(3) Services, including audiometric testing, hearing aid evaluations, fittings and adjustments; and

(4) At least one annual audiological evaluation.

(b) For purposes of this section, “hearing aid” means any wearable device or instrument or any combination thereof, designated for, represented as or offered for sale for the purpose of aiding, improving or compensating for defective or impaired human hearing and includes ear molds, parts, attachments or other medically necessary accessories, but excludes batteries and cords.

(c) The same deductibles, coinsurance, network restrictions and other limitations for covered services found in the policy, provision, contract, plan or agreement of the covered individuals apply to hearing aids covered pursuant to this section. Required coverage is further limited to the cost of one hearing aid including all covered hearing aid-related services not to exceed an aggregate of $1,400 per hearing-impaired ear every 36 months. The insured may choose a higher priced hearing aid and may pay the difference in cost above the $1,400 limit as provided in this section without any financial or contractual penalty to the insured or to the provider of the hearing aid.

(d) To the extent that the provisions of this section require benefits that exceed the essential health benefits specified under section 1302(b) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, the specific benefits that exceed the specified essential health benefits are not required of a health benefit plan when the plan is offered by a health care insurer in this state.

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§33-16-3aaa. Required coverage for hearing aids.

(a) A policy, plan, or contract that is issued or renewed on or after January 1, 2026, shall

provide coverage for the cost of hearing aids that are prescribed by a licensed physician for individuals covered under the policy or plan. The policy or plan shall at a minimum provide coverage for:

(1) Initial hearing aids and replacement hearing aids at least as frequently as every 36 months;

(2) New hearing aids when alterations to the existing hearing aids cannot adequately meet the needs of the covered individual;

(3) Services, including audiometric testing, hearing aid evaluations, fittings and adjustments; and

(4) At least one annual audiological evaluation.

(b) For purposes of this section, “hearing aid” means any wearable device or instrument or any combination thereof, designated for, represented as or offered for sale for the purpose of aiding, improving or compensating for defective or impaired human hearing and includes ear molds, parts, attachments or other medically necessary accessories, but excludes batteries and cords.

(c) The same deductibles, coinsurance, network restrictions and other limitations for covered services found in the policy, provision, contract, plan or agreement of the covered individuals apply to hearing aids covered pursuant to this section. Required coverage is further limited to the cost of one hearing aid including all covered hearing aid-related services not to exceed an aggregate of $1,400 per hearing-impaired ear every 36 months. The insured may choose a higher priced hearing aid and may pay the difference in cost above the $1,400 limit as provided in this section without any financial or contractual penalty to the insured or to the provider of the hearing aid.

(d) To the extent that the provisions of this section require benefits that exceed the essential health benefits specified under section 1302(b) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, the specific benefits that exceed the specified

essential health benefits are not required of a health benefit plan when the plan is offered by a health care insurer in this state.

ARTICLE 24. HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS, DENTAL SERVICE CORPORATIONS AND HEALTH SERVICE CORPORATIONS.

§33-24-7z. Required coverage for hearing aids.

(a) A policy, plan, or contract that is issued or renewed on or after January 1, 2026, shall provide coverage for the cost of hearing aids that are prescribed by a licensed physician for individuals covered under the policy or plan. The policy or plan shall at a minimum provide coverage for:

(1) Initial hearing aids and replacement hearing aids at least as frequently as every 36 months;

(2) New hearing aids when alterations to the existing hearing aids cannot adequately meet the needs of the covered individual;

(3) Services, including audiometric testing, hearing aid evaluations, fittings and adjustments; and

(4) At least one annual audiological evaluation.

(b) For purposes of this section, “hearing aid” means any wearable device or instrument or any combination thereof, designated for, represented as or offered for sale for the purpose of aiding, improving or compensating for defective or impaired human hearing and includes ear molds, parts, attachments or other medically necessary accessories, but excludes batteries and cords.

(c) The same deductibles, coinsurance, network restrictions and other limitations for covered services found in the policy, provision, contract, plan or agreement of the covered individuals apply to hearing aids covered pursuant to this section. Required coverage is further

limited to the cost of one hearing aid including all covered hearing aid-related services not to exceed an aggregate of $1,400 per hearing-impaired ear every 36 months. The insured may choose a higher priced hearing aid and may pay the difference in cost above the $1,400 limit as provided in this section without any financial or contractual penalty to the insured or to the provider of the hearing aid.

(d) To the extent that the provisions of this section require benefits that exceed the essential health benefits specified under section 1302(b) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, the specific benefits that exceed the specified essential health benefits are not required of a health benefit plan when the plan is offered by a health care insurer in this state.

ARTICLE 25. HEALTH CARE CORPORATIONS.

§33-25-8w. Required coverage for hearing aids.

(a) A policy, plan, or contract that is issued or renewed on or after January 1, 2026, shall provide coverage for the cost of hearing aids that are prescribed by a licensed physician for individuals covered under the policy or plan. The policy or plan shall at a minimum provide coverage for:

(1) Initial hearing aids and replacement hearing aids at least as frequently as every 36 months;

(2) New hearing aids when alterations to the existing hearing aids cannot adequately meet the needs of the covered individual;

(3) Services, including audiometric testing, hearing aid evaluations, fittings and adjustments; and

(4) At least one annual audiological evaluation.

(b) For purposes of this section, “hearing aid” means any wearable device or instrument or any combination thereof, designated for, represented as or offered for sale for the purpose of aiding, improving or compensating for defective or impaired human hearing and includes ear

molds, parts, attachments or other medically necessary accessories, but excludes batteries and cords.

(c) The same deductibles, coinsurance, network restrictions and other limitations for covered services found in the policy, provision, contract, plan or agreement of the covered individuals apply to hearing aids covered pursuant to this section. Required coverage is further limited to the cost of one hearing aid including all covered hearing aid-related services not to exceed an aggregate of $1,400 per hearing-impaired ear every 36 months. The insured may choose a higher priced hearing aid and may pay the difference in cost above the $1,400 limit as provided in this section without any financial or contractual penalty to the insured or to the provider of the hearing aid.

(d) To the extent that the provisions of this section require benefits that exceed the essential health benefits specified under section 1302(b) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, the specific benefits that exceed the specified essential health benefits are not required of a health benefit plan when the plan is offered by a health care insurer in this state.

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

§33-25A-8z. Required coverage for hearing aids.

(a) A policy, plan, or contract that is issued or renewed on or after January 1, 2026, shall provide coverage for the cost of hearing aids that are prescribed by a licensed physician for individuals covered under the policy or plan. The policy or plan shall at a minimum provide coverage for:

(1) Initial hearing aids and replacement hearing aids at least as frequently as every 36 months;

(2) New hearing aids when alterations to the existing hearing aids cannot adequately meet the needs of the covered individual;

(3) Services, including audiometric testing, hearing aid evaluations, fittings and adjustments; and

(4) At least one annual audiological evaluation.

(b) For purposes of this section, “hearing aid” means any wearable device or instrument or any combination thereof, designated for, represented as or offered for sale for the purpose of aiding, improving or compensating for defective or impaired human hearing and includes ear molds, parts, attachments or other medically necessary accessories, but excludes batteries and cords.

(c) The same deductibles, coinsurance, network restrictions and other limitations for covered services found in the policy, provision, contract, plan or agreement of the covered individuals apply to hearing aids covered pursuant to this section. Required coverage is further limited to the cost of one hearing aid including all covered hearing aid-related services not to exceed an aggregate of $1,400 per hearing-impaired ear every 36 months. The insured may choose a higher priced hearing aid and may pay the difference in cost above the $1,400 limit as provided in this section without any financial or contractual penalty to the insured or to the provider of the hearing aid.

(d) To the extent that the provisions of this section require benefits that exceed the essential health benefits specified under section 1302(b) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, the specific benefits that exceed the specified essential health benefits are not required of a health benefit plan when the plan is offered by a health care insurer in this state.

NOTE: The purpose of this bill is to require health insurance coverage of hearing aids.

Strike-throughs indicate language that would be stricken from a heading or the present law and underscoring indicates new language that would be added.