A REPORT TO THE 2025–2026 CALIFORNIA LEGISLATURE

Analysis of California Assembly Bill 1032: Coverage for Behavioral Health Visits

APRIL 20, 2025

CHBRP

California Health Benefits Review Program (CHBRP)
University of California, Berkeley

chbrp.org

KEY FINDINGS

Analysis of California Assembly Bill 1032: Coverage for Behavioral Health Visits

Summary to the 2025–2026 California State Legislature, April 20, 2025

CHBRP

Summary

The version of California Assembly Bill (AB) 1032 analyzed by the California Health Benefits Review Program (CHBRP) would require an individual or group health care service plan contract or health insurance policy to reimburse up to 12 visits per year with a licensed behavioral health provider for an enrollee or insured in a county where an emergency has been declared due to wildfires. The benefits would last until 1 year from the date the local or state emergency is lifted, whichever is later.

In 2026, of the 22.2 million Californians enrolled in state-regulated health insurance, 13.6 million would have insurance subject to AB 1032. Medi-Cal is exempt.

Benefit Coverage

At baseline, all enrollees in commercial and California Public Employees' Retirement System (CalPERS) Department of Managed Health Care (DMHC)-regulated plans and California Department of Insurance (CDI)-regulated policies have coverage for behavioral health visits regardless of whether or not there is a wildfire. None have coverage that allows them to see any licensed behavioral health provider (contracted with their plan or not) and be reimbursed after the visit. Postmandate, 100% of enrollees would have coverage. AB 1032 does not expand coverage per se but rather expands access to out-of-network coverage. The enrollee would need to pay for behavioral health visits and then be reimbursed by the insurer, less any cost sharing. AB 1032 would not exceed the definition of essential health benefits (EHBs) in California.

Medical Effectiveness

A large body of literature shows that psychotherapy and pharmacotherapy treatments are *effective* for people experiencing post-traumatic stress disorder (PTSD), anxiety, depression, substance use disorder (SUD), and sleep disturbances as part *of general trauma care*. There is *not enough research* to assess the effectiveness of these treatments on behavioral health conditions *rooted in experience with any kind of natural disaster*.

Despite the dearth of literature, CHBRP does not have a reason to believe these therapies, which are effective for treating behavioral health conditions generally, would not also be effective for people seeking treatment due to trauma rooted in experience with a natural disaster.

Cost and Health Impacts

AB 1032 would increase total net annual expenditures by $49,966,000 (0.03%) for enrollees with plans regulated by the DMHC and policies regulated by the CDI. This is due to an increase of $43,747,000 in total health insurance premiums paid by employers and enrollees, and a $6,219,000 increase in enrollee cost sharing.

In the first year postmandate, among the 13,570,000 people with health insurance subject to AB 1032, an estimated 3,586,000 enrollees in counties with an emergency declaration due to wildfires could experience a change in benefit coverage. An estimated 16,170 people would increase behavioral health services use due to AB 1032; of these, 6,240 people would be directly impacted from the wildfires, and 9,930 would have existing unmet needs.

There would be improved behavioral health outcomes in the first year postmandate among the population of people who reside in a county with an emergency declaration due to wildfires, have a behavioral health need, have the ability to pay out of pocket for out-of-network care, and who ultimately utilize care and have the cost of behavioral health visits reimbursed.

A state emergency declaration due to a wildfire often lasts longer than the initial first few months past the date of the disaster event. Since there may be a time lag between when a wildfire event occurs and people's need for behavioral health services, utilization postmandate may extend past 1 year. As need continues, and to the extent that plans and policies are required to provide coverage under AB 1032, utilization and cost could increase marginally, and there could be longer-term public health impacts.

Context

In California, wildfires have increased in frequency and caused more damage to land, structures, and people over the past few decades. The past 10 years have seen some of the most destructive and deadliest fires in California history, including the 2018 Camp Fire and 2025 Eaton Fire.

Serious wildfires can result in harmful environmental conditions such as smoke and poor water quality, and disrupt residents' way of life through forced evacuations and burned or damaged property, land, and structures, as well as through the loss or fracture of jobs, income, social and community networks, food and water security, and more.

Residents of an affected region can experience adverse physical and behavioral health conditions that last beyond the end of the fire. Common behavioral health conditions among people impacted by wildfires and other natural disasters are post-traumatic stress disorder (PTSD), anxiety, depression, sleep disorders, general mood or behavior disorders, and substance use disorder (SUD).[1] Individuals who lose loved ones are at greater risk for serious psychological distress.

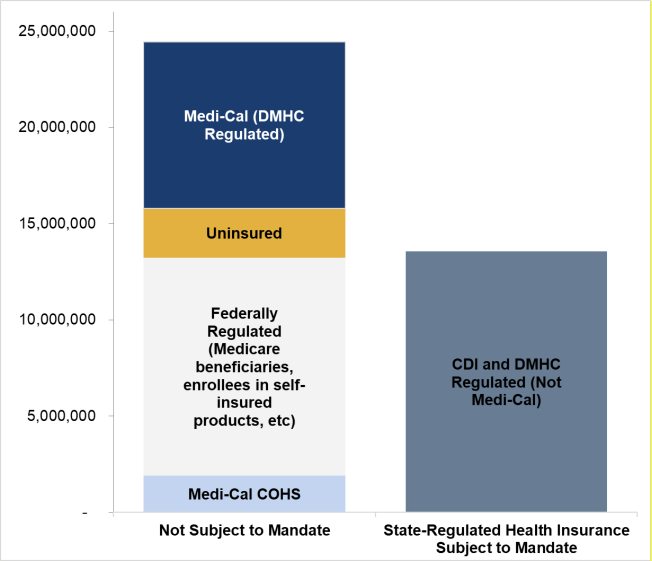
Bill Summary

AB 1032 would require an individual or group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, to reimburse an eligible enrollee or insured for up to 12 visits per year with a licensed behavioral health provider if the enrollee or insured is in a county where a local or state emergency has been declared due to wildfires. An enrollee or insured would be entitled to those benefits until 1 year from the date the local or state emergency is lifted, whichever is later. For enrollees in a Health Savings Account (HSA)-qualified high deductible health plan (HDHP), the benefit would only apply once an enrollee's deductible has been met for the year. Enrollees would be reimbursed for the cost of behavioral health visits, less their cost sharing responsibility. Prescription drugs prescribed by a licensed behavioral health provider would be covered through an enrollee's pharmacy benefit.

Existing law requires coverage for behavioral health visits, and AB 1032 would place additional requirements on health plans and policies such that enrollees could receive care from any licensed behavioral health provider, whether or not their health plan contracts with the provider. Because state emergency declarations can last longer than 1 year, some enrollees could use this benefit beyond 1 year.

Figure A shows how many Californians have health insurance that would be subject to AB 1032.

Figure A. Health Insurance in CA and AB 1032



Source: California Health Benefits Review Program, 2025.
Note: CHBRP generally assumes alignment of Medi-Cal managed care plan benefits, with limited exceptions.[2]
Key: CDI = California Department of Insurance; COHS = County Organized Health System; DHCS = Department of Health Care Services; DMHC = Department of Managed Health Care.

Impacts

Benefit Coverage

All those eligible for coverage under AB 1032 currently have coverage for behavioral health services regardless of whether or not there is a wildfire. AB 1032 does not

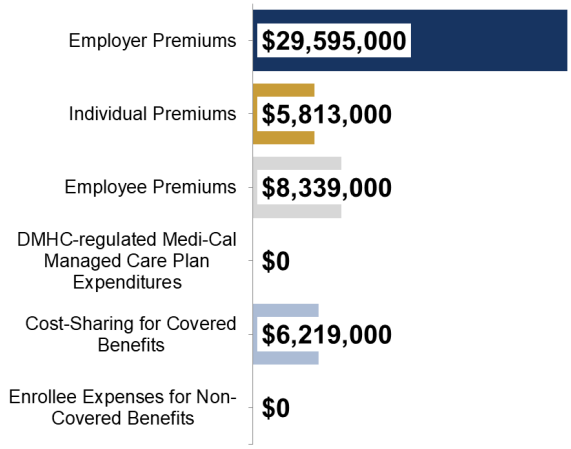
[1] Refer to CHBRP's full report for full citations and references.
[2] Although COHS plans are not subject to the Knox-Keene Act, DHCS generally updates Medi-Cal managed care plan contracts, All Plan Letters, and other appropriate authorities for alignment of managed care plan benefits, except in cases when the benefit is carved out of the Medi-Cal managed care plan contract or the law exempts specified Medi-Cal contracted providers.

expand coverage per se but rather expands access to out-of-network coverage. The enrollee would need to pay for behavioral health visits and then be reimbursed by the insurer, less any cost sharing. Postmandate, 100% of commercial/California Public Employees' Retirement System (CalPERS) plans regulated by the Department of Managed Health Care (DMHC) and policies regulated by the California Department of Insurance (CDI) would have coverage in compliance with AB 1032.

How does utilization impact premiums?

Health insurance, by design, distributes risk and expenditures across everyone enrolled in a plan or policy. It does so to help protect each enrollee from the full impact of health care costs that arise from that enrollee's use of prevention, diagnosis, and/or treatment of a covered medical condition, disease, or injury. Changes in utilization among any enrollees in a plan or policy can result in changes to premiums for all enrollees in that plan or policy.

Figure B. Expenditure Impacts of AB 1032



Source: California Health Benefits Review Program, 2025.

Utilization

It is estimated that an additional 16,170 people (6,240 utilizing for wildfire-related reasons and 9,930 people with previously unmet needs) would have a total of 194,050 more behavioral health visits (assuming each enrollee receives 12 visits within the first year postmandate) as a result of AB 1032.

Expenditures

AB 1032 would increase total net annual expenditures by $49,966,000 (0.03%) for enrollees with commercial/CalPERS plans and policies. This is due to an increase of $43,747,000 in total health insurance premiums paid by employers and enrollees, and a $6,219,000 increase in enrollee cost sharing. See Figure B.

Commercial

Premium increases as a result of AB 1032 would total $43.7 million for all aspects of the Commercial market. Premiums would increase among DMHC-regulated commercial plans, ranging from $0.22 per member per month (PMPM) for individual plans to $0.28 PMPM for large-group plans. Among CDI-regulated policies, premiums would increase from $0.25 PMPM for small-group plans to $0.28 PMPM for individual and large-group plans.

Medi-Cal

Medi-Cal is not included in AB 1032.

CalPERS

For enrollees associated with CalPERS in DMHC-regulated plans, premiums could be expected to increase by $2,709,000, or $0.29 PMPM.

Covered California – Individually Purchased

For enrollees whose plans are purchased inside the Covered California marketplace, premiums would increase by $4,195,000.

Number of Uninsured in California

Because the change in average premiums does not exceed 1% for any market segment, CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of AB 1032.

Medical Effectiveness

The medical effectiveness review summarizes findings from evidence on the impact of visits with licensed behavioral health providers on the following behavioral health conditions generally and when they are rooted in experience with any kind of natural disaster: PTSD, depression, anxiety, SUD, and sleep disturbances.

CHBRP identified a large body of literature demonstrating that psychotherapy and pharmacotherapy treatments are effective for people experiencing PTSD, anxiety, depression, SUD, and sleep disturbances as part of general trauma care. The medical effectiveness review reached the following conclusions for *people experiencing general trauma*.

For *psychotherapy*:

- There is *very strong evidence*[3] that psychotherapy is effective at reducing *PTSD* prevalence and symptoms.
- There is *strong evidence*[4] that psychotherapy is effective at reducing *depression* prevalence and symptoms.
- There is *very strong evidence* that psychotherapy is effective at reducing *anxiety* prevalence and symptoms.
- There is *some evidence*[5] that psychotherapy is effective at reducing *SUD* prevalence and symptoms.
- There is *some evidence* that psychotherapy is effective at reducing *sleep disturbance* prevalence and symptoms.

For *pharmacotherapy*:

- There is *strong evidence* that pharmacotherapy is effective at reducing *PTSD* prevalence and symptoms.
- There is *strong evidence* that pharmacotherapy is effective at reducing *depression* prevalence and symptoms.
- There is *strong evidence* that pharmacotherapy is effective at reducing *anxiety* prevalence and symptoms.
- There is *some evidence* that pharmacotherapy is effective at reducing *SUD* prevalence and symptoms.
- There is *strong evidence* that pharmacotherapy is effective at reducing *sleep disturbance* prevalence and symptoms.

• Behavioral Health Condition	Psychotherapy Effectiveness	Pharmacotherapy Effectiveness
PTSD	Very strong evidence	Strong evidence
Depression	Strong evidence	Strong evidence
Anxiety	Very strong evidence	Strong evidence
SUD	Some evidence	Some evidence
Sleep disturbance	Some evidence	Strong evidence

CHBRP identified scant literature specific to the effectiveness of psychotherapy and pharmacotherapy treatments for PTSD, anxiety, depression, SUD, and sleep disturbances among people who have experienced natural disasters. Despite the dearth of literature, CHBRP does not have a reason to believe these therapies, which are effective for treating behavioral health conditions generally, would not also be effective for people seeking treatment due to trauma rooted in experience with a natural disaster. CHBRP considers the following medical effectiveness review conclusions specific to the natural disaster-experiencing

[3] *Very strong evidence* indicates that there are multiple studies of a treatment, and the large majority of studies are of high quality and consistently find that the treatment is either effective or not effective. Conclusions are unlikely to be altered by additional evidence.

[4] *Strong evidence* indicates that the majority of the studies reviewed are consistent in their findings that treatment is either effective or not effective. Conclusions could be altered with additional strong evidence.

[5] *Strong evidence* indicates that the majority of the studies reviewed are consistent in their findings that treatment is either effective or not effective. Conclusions could be altered with additional strong evidence.

population as complementary to the above-described literature and conclusions about general trauma care.

Among *people experiencing a natural disaster*:

- There is *not enough research*[6] that psychosocial treatment is effective at reducing trauma symptoms for children.
- There is *not enough research* that eye movement desensitization and reprocessing treatment (EMDR) is effective at reducing PTSD, anxiety, and depression for children.
- There is *some evidence* that cognitive behavioral therapy (CBT) is effective at reducing PTSD diagnoses, PTSD symptoms, depression, and anxiety for children.
- There is *not enough research* that CBT is effective at reducing postdisaster distress for adults.
- There is *not enough research* that pharmacotherapy is effective at reducing PTSD, depression, anxiety, SUD, and sleep disturbances for children or adults.

Public Health

In the first year postmandate, there would be improved behavioral health outcomes among the population of people who reside in a county with a local or state emergency declaration due to wildfires, have a behavioral health need, have the ability to pay out of pocket for out-of-network care, and who ultimately utilize care and have the cost of behavioral health visits reimbursed. The positive public health outcomes are supported by strong evidence that psychotherapy and pharmacotherapy are medically effective treatments for PTSD, anxiety, and depression; strong evidence that pharmacotherapy is effective at treating sleep disturbances; and some evidence that psychotherapy and pharmacotherapy are effective at treating SUD.

CHBRP has insufficient information to estimate the impact of AB 1032 on disparities by group within the first 12 months postmandate. However, to the extent that AB 1032 would increase access among higher-income people and families who could afford to pay out of pocket before receiving reimbursement, there could be disparate impacts; in such cases, lower-income families might not be able to pay for care upfront before being reimbursed by their plan or policy.

Long-Term Impacts

A state emergency declaration due to a wildfire often lasts longer than the initial first few months past the date of the disaster event. Coverage under AB 1032 would go through 1 year following the end of the emergency period, but wildfire impacts can last longer.

To the extent that emergency declarations in counties impacted by wildfires continue, utilization of behavioral health services could increase past the first year postmandate. Since there may be a time lag between when a wildfire event occurs and people's need for behavioral health services, utilization postmandate may extend past 1 year. Additionally, severity of conditions may change over time. As need continues, and to the extent that plans and policies are required to provide coverage under AB 1032, utilization could increase marginally.

Should utilization of behavioral health visits increase, premiums and enrollee cost sharing would increase proportionately.

There could be longer-term public health impacts of behavioral health services utilization as provided under AB 1032. For instance, since trauma-induced anxiety and depression tend to persist longer past a disaster event, increased access to and use of care may lead to improved outcomes in the long term. Outcomes for PTSD may also improve in the long term to the extent that affected populations receive timely and consistent treatment. In addition, it may take weeks or months for the health benefits of psychotherapy and pharmacotherapy to be fully realized.

Essential Health Benefits and the Affordable Care Act

Coverage for behavioral health visits is already an essential health benefit (EHB), so AB 1032 is assumed to not exceed EHBs.

[6] *Not enough research* indicates that there are no studies of the treatment, or the available studies are not of high quality, meaning there is not enough evidence available to know whether or not a treatment is effective. It does not indicate that a treatment is not effective.

About CHBRP

The California Health Benefits Review Program (CHBRP) was established in 2002. As per its authorizing statute, CHBRP provides the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation.

The state funds CHBRP through an annual assessment on health plans and insurers in California.

An analytic staff based at the University of California, Berkeley, supports a task force of faculty and research staff from multiple University of California campuses to complete each CHBRP analysis. A strict conflict-of-interest policy ensures that the analyses are undertaken without bias. A certified, independent actuary helps to estimate the financial impact. Content experts with comprehensive subject-matter expertise are consulted to provide essential background and input on the analytic approach for each report.

More detailed information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications, are available at chbrp.org.

Suggested citation

California Health Benefits Review Program (CHBRP). (2025). *Analysis of California Assembly Bill 1032 Coverage for Behavioral Health Visits.* Berkeley, CA.

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Lists of Tables and Figures

Acronyms and Abbreviations

AB – Assembly Bill
ACA – Affordable Care Act
CA – California
CalPERS – California Public Employees' Retirement System
CBITS – Cognitive-Behavioral Intervention for Trauma in Schools
CBT – cognitive behavioral therapy
CBT-PD – cognitive behavioral therapy for postdisaster distress
CDI – California Department of Insurance
CHBRP – California Health Benefits Review Program
CHSD – Consolidated Health Cost Guidelines Sources Database
COHS – County Organized Health System
CRI – Child PTSD Reaction Index
DHCS – Department of Health Care Services
DMHC – Department of Managed Health Care
EHB – essential health benefits
EMDR – eye movement desensitization and reprocessing
FEMA – Federal Emergency Management Agency
HCGs – Health Cost Guidelines
HDHP – high deductible health plan
HMO – health maintenance organization
HSA – Health Savings Account
HSC – Health & Safety Code
INS – Insurance Code
IRS – Internal Revenue Service
KRI – Kauai Recovery Inventory
LACDMH – Los Angeles County Department of Mental Health
MHPAEA – Mental Health Parity and Addiction Equity Act
PMPM – per member per month
PPO – preferred provider organization
PTSD – post-traumatic stress disorder
SAMHSA – Substance Abuse and Mental Health Services Administration
SB – Senate Bill
STEP – School Therapeutic Enhancement Program
SUD – substance use disorder
TF-CBT – trauma-focused cognitive behavioral therapy

Introduction

The California Assembly Committee on Health requested that the California Health Benefits Review Program (CHBRP)[7] conduct an evidence-based assessment of the medical, financial, and public health impacts of Assembly Bill (AB) 1032, Coverage for Behavioral Health Visits.

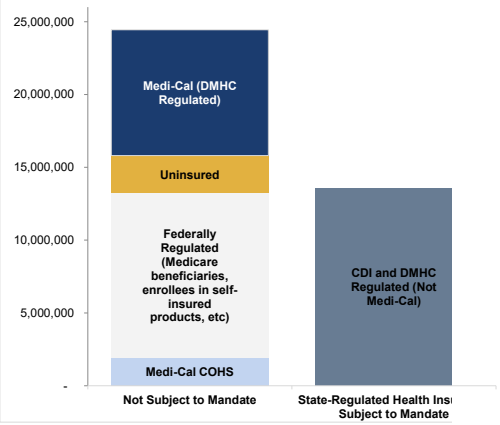
AB 1032, Coverage for Behavioral Health Visits Bill Language

AB 1032 would require an individual or group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, to reimburse an eligible enrollee or insured for up to 12 visits per year with a licensed behavioral health[8] provider if the enrollee or insured is in a county where a local or state emergency has been declared due to wildfires. An enrollee or insured would be entitled to those benefits until 1 year from the date the local or state emergency is lifted, whichever is later. For enrollees in a Health Savings Account (HSA)-qualified high deductible health plan (HDHP), the benefit would only apply once an enrollee's deductible has been met for the year.

Existing law requires coverage for behavioral health visits, and AB 1032 would place additional requirements on health plans and policies such that enrollees could receive care from any licensed behavioral health provider, whether or not their health plan contracts with the provider. Because state emergency declarations can last longer than 1 year, some enrollees could use this benefit beyond 1 year. See the full text of AB 1032 in Appendix A.

If enacted, AB 1032 would apply to the health insurance of approximately 13,570,000 enrollees (35.7% of all Californians) (see Figure 1).

Figure 1. Health Insurance in CA and AB 1032



Source: California Health Benefits Review Program, 2025.
Note: CHBRP generally assumes alignment of Medi-Cal managed care plan benefits, with limited exceptions.[1]
Key: CDI = California Department of Insurance; COHS = County Organized Health System; DHCS = Department of Health Care Services; DMHC = Department of Managed Health Care.

- **Includes**: enrollees in commercial or California Public Employees' Retirement System (CalPERS) health insurance regulated by the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI).
- **Excludes**: Medi-Cal beneficiaries.

See the following *Analytic Approach and Key Assumptions* section for additional information.

Wildfires and Impacts on Behavioral Health

In California, the number of wildfires and the number of people affected by them has varied tremendously, but wildfires have increased in frequency and caused more damage to land, structures, and people over the past few decades (Buechi et al., 2019). The past 10 years alone have seen some of the most destructive and deadliest fires in California history, including the 2018 Camp Fire and 2025 Eaton Fire.

Serious wildfires can result in harmful environmental conditions such as smoke and poor water quality, and disrupt residents' way of life through forced evacuations and burned or damaged property, land, and structures, as well as through the loss or fracture of jobs, income, social and community networks, food and water security, and more. On a

[7] See CHBRP's authorizing statute.
[8] In this report, the term behavioral health is considered to include both mental health and substance use disorder (SUD). Much of the published literature focuses on mental health or SUD, so CHBRP retains the use of those terms when citing published sources.

more individual and short-term level, wildfires can disrupt daily routines for people with behavioral health conditions as well those without, and interfere with access to care, providers, facilities, and medications. Residents of an affected region can experience adverse physical and behavioral health conditions that last beyond the end of the fire. Such circumstances can cause or exacerbate respiratory conditions, sleep disorders, hypertension, and mental health and substance use disorders, among others (Howard et al., 2021). Common behavioral health conditions among people impacted by wildfires and other natural disasters are post-traumatic stress disorder (PTSD), anxiety, depression, sleep disorders, general mood or behavior disorders, and substance use disorder. Individuals who lose loved ones are at greater risk for serious psychological distress.

Terminology

AB 1032 includes the following definition:

- "Licensed behavioral health provider" means a provider licensed under Division 2 (commencing with Section 500) of the Business and Professions Code authorized to render behavioral health services.

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Analytic Approach and Assumptions

- Because AB 1032 specifies "group and individual" plans and policies, the health insurance of Medi-Cal beneficiaries would not be subject to AB 1032's requirements.[9]

- AB 1032 would not provide more behavioral health visits to enrollees; rather, enrollees could seek care from an out-of-network provider who is accepting new patients and be reimbursed for their costs. Enrollee cost sharing is assumed to apply.

- Because AB 1032 is silent on what types of services would be included in a "behavioral health visit," services provided by a licensed behavioral health provider are assumed to be provided on an outpatient basis and include in-person and telehealth therapy visits, as well as individual and group therapy visits, for mental health conditions and substance use disorders. Applied Behavior Analysis, a therapy based on the science of learning and behavior, commonly used to help individuals with autism, is excluded.

- Enrollees in Health Savings Account (HSA)-qualified high deductible health plans (HDHPs) are included in CHBRP's cost model. See the *Cost* section for more details on this assumption.

- AB 1032 is silent on coverage for prescription drugs prescribed as part of a behavioral health visit, and CHBRP assumes that prescription drugs would be covered through an enrollee's pharmacy benefit.

- AB 1032 includes an urgency clause, so it could take effect immediately upon signature by the Governor.

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[9] Personal communication, Office of Legislative and Governmental Affairs, California Department of Health Care Services, November 2024.

Policy Context

Health benefit mandates may interact and align with the following state and federal mandates, programs, and policies.

California Law and Regulations

CA Health & Safety Code (HSC) § 1368.7 requires health care service plans to provide enrollees who are displaced or whose health may otherwise be affected by a state of emergency access to medically necessary health care services. Within 48 hours of an emergency declaration, a health care service plan operating in the county or counties included in the declaration must file with the Department of Managed Health Care (DMHC) a notification describing whether the plan has experienced or expects to experience any disruption to the operation of the plan, explaining how the plan is communicating with potentially impacted enrollees, and summarizing the actions the plan has taken or is taking to ensure that the health care needs of enrollees are met. DMHC may require the plan to take actions, including allowing impacted enrollees to refill their prescriptions at an out-of-network pharmacy, access an appropriate out-of-network provider if an in-network provider is unavailable due to the state of emergency or if the enrollee is out of the area due to displacement, and have a toll-free phone number that enrollees may call for answers to questions.

Mental Health Parity

California law[10] requires plans and policies to cover all mental health and substance use disorders listed in the most recent edition of either the *International Classification of Diseases* or the *Diagnostic and Statistical Manual of Mental Disorders* at parity with other medical services. This requirement is similar to those specified by the federal Mental Health Parity and Addiction Equity Act (MHPAEA, see below), but applies to all health insurance plans and policies subject to either the Health and Safety Code or the Insurance Code.

Other Relevant California Programs

California has a variety of programs to assist people affected by wildfires and other disasters, but none specifically covers multiple behavioral health visits with a licensed behavioral health provider. The California Department of Public Health website provides links to crisis hotlines, warmlines, and other resources, including some of those described below.

The 988 Suicide & Crisis Lifeline, funded by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week, across the United States and its territories.

Typically staffed by peers (paid or volunteer) that have experience with mental health challenges, warm lines provide comfort and support during challenging times. As one example, the California Peer-Run Warm Line provides peer-led, noncoercive, and stigma-reducing support that addresses a wide range of challenges, including anxiety, depression, and substance use.

The CalHOPE program, which is funded by the Federal Emergency Management Agency (FEMA) and administered by the California Department of Health Care Services (DHCS), delivers crisis support for communities impacted by a national disaster. CalHOPE builds community resiliency and helps people recover from disasters through free outreach, crisis counseling, and support services. As one example, the Sonoma County Department of Health Services launched its CalHOPE program as part of the County's recovery response to the October 2017 fires to help individuals and communities recover from natural and human-caused disasters through community outreach and access to mental health

[10] Health and Safety Code (HSC) Section 1374.72; Insurance Code (INS) Section 10144.5 and 10123.15.

services. Initial recovery work through the program was supported by short-term disaster relief grants from FEMA, with subsequent grant support from Kaiser Permanente Northern California Community Benefit.

The Los Angeles County Department of Mental Health (LACDMH) provides 24/7 support and resources to people experiencing mental health distress related to the wildfires in California, via a phone Help Line. LACDMH staff are available to provide in-person mental health services (e.g., counseling, medication assistance, crisis stabilization) at LA County Disaster Recovery Centers. LACDMH staff have provided services at evacuation shelters, animal evacuation sites, and youth camps, and they are also present at re-entry points and in wildfire-impacted neighborhoods to provide resources and support.

Health plans in California offer help to people affected by wildfires and other disasters, some of which are required by the state during a disaster (see CA Health & Safety Code § 1368.7) and others that are not. As examples in response to the 2025 Los Angeles fires, some health plans are providing some services to anyone (members and non-members) affected by the wildfires (e.g., seeking referrals or help to cope with the emotional impact of the wildfires; clinical support to help with anxiety, stress, or other issues; a free emotional-support help line) (Word & Brown, 2025).

Similar Legislation in Other States

Legislation in several states requires health insurers to cover a broader range of behavioral health services, and to increase rates paid to behavioral health providers, but CHBRP is not aware of any other state laws that require health plans to reimburse enrollees or insureds for behavioral health visits after a wildfire.

Federal Policy Landscape

Federal Mental Health Parity and Addiction Equity Act

The federal Mental Health Parity and Addiction Equity Act (MHPAEA) addresses parity for behavioral health benefits.[11] The MHPAEA requires that when mental health or substance use disorder services are covered, cost-sharing terms and treatment limits be no more restrictive than the predominant terms or limits applied to medical/surgical benefits. Furthermore, for any behavioral health benefits that are covered, coverage must be provided in all classification of benefits (e.g., inpatient in-network benefits, prescription drug benefits, emergency care benefits) in which comparative medical/surgical benefits are provided. The law protects enrollees from facing greater restrictions on access to behavioral health benefits as compared to medical/surgical benefits. The MHPAEA directly applies to large-group health insurance, but the Affordable Care Act (ACA) requires small-group and individual market plans and policies purchased through a state health insurance marketplace to comply with the MHPAEA. This federal requirement is similar to the California mental health parity law described previously,[12] although the state law applies to some plans and policies not captured in the MHPAEA. Under AB 1032, enrollees would be eligible for reimbursement for the costs of up to 12 behavioral health visits per calendar year. CHBRP does not believe the additional out-of-network reimbursement provisions of AB 1032 violate mental health parity requirements.

High Deductible Health Plans and Health Savings Account (HSA)-Qualified HDHPs

High deductible health plans (HDHPs) are a type of health plan with requirements set by federal regulation.[13,14] As the name implies, these plans include a deductible – but they are not allowed to have separate medical and pharmacy deductibles. For the 2025 plan year, the Internal Revenue Service (IRS) defines an HDHP as any plan with a deductible of at least $1,650 for an individual and $3,300 for a family.[15] Annual out-of-pocket expenses for coverage of in-network tests,

[11] Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as amended by the ACA.
[12] HSC Section 1374.72; INS Section 10144.5 and 10123.15.
[13] For enrollment estimates, see CHBRP's resource *Deductibles in State-Regulated Health Insurance*.
[14] HealthCare.gov, Glossary: High Deductible Health Plan (HDHP). Accessed March 5, 2021.
[15] IRS Revenue Procedure 2024-25.4.

treatments, and services, which would result from cost sharing[16] applicable after the deductible is met, are not allowed to be more than $8,300 for an individual and $16,600 for a family.[17]

To be eligible to establish an HSA for taxable years beginning after December 31, 2003[18] (and so to be eligible to make tax-favored contributions to an HSA), a person must be enrolled in an HSA-qualified HDHP.

In order for an HDHP to be HSA-qualified, it must follow specified rules regarding cost sharing and deductibles, as set by the IRS. Generally, an HDHP may not provide benefits for any year until the deductible for that year is satisfied – but federal law provides a safe harbor for the absence of a deductible applicable to preventive care.[19] Therefore an HDHP may cover preventive care benefits without any deductible or with a deductible below the minimum annual deductible – but is not required to do so for a specified list of preventive services.

Affordable Care Act

A number of Affordable Care Act (ACA) provisions have the potential to or do interact with state benefit mandates. Below is an analysis of how AB 1032 may interact with requirements of the ACA as presently exist in federal law, including the requirement for certain health insurance to cover essential health benefits (EHBs).[20,21]

Essential health benefits

In California, nongrandfathered[22] individual and small-group health insurance is generally required to cover essential health benefits (EHBs).[23] In 2026, approximately 11% of all Californians will be enrolled in a plan or policy that must cover EHBs.[24]

Because behavioral health services, including behavioral health treatment, are an EHB, AB 1032 would not require coverage for a new state benefit mandate that appears to exceed the definition of EHBs in California.

Other Federal or State Programs

In response to the 2022 New Mexico Hermit's Peak/Calf Canyon Fire, the largest and most destructive wildfire in the state, FEMA made funds available to people impacted by the wildfire for mental health treatment for conditions resulting from, or worsened by, the fire and subsequent flooding. Compensation was available to reimburse impacted people for out-of-pocket medical and mental health expenses or compensate them for future mental health treatment by a licensed mental health professional. Claimants were required to submit supporting documentation that includes treatment costs and confirms mental health treatment is directly related to conditions resulting from, or worsened by, the fire.

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[16] Such as copayments and coinsurance applicable to the covered test, treatment, or service.
[17] There is no annual out-of-pocket expenses limit for coverage of out-of-network tests, treatments, and services.
[18] Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, added section 223 to the Internal Revenue Code.
[19] For more information on screening services, see Notice 2004-23, 2004-15 I.R.B. 725.
For additional guidance on preventive care, see Notice 2004-50, 2004-2 C.B. 196, Q&A 26 and 27; and Notice 2013-57, 2013-40 I.R.B. 293.
[20] The ACA requires nongrandfathered small-group and individual market health insurance – including, but not limited to, qualified health plans sold in Covered California – to cover 10 specified categories of EHBs. Policy and issue briefs on EHBs and other ACA impacts are available on the CHBRP website.
[21] Although many provisions of the ACA have been codified in California law, the ACA was established by the federal government, and therefore, CHBRP generally discusses the ACA as a federal law.
[22] A grandfathered health plan is "a group health plan that was created – or an individual health insurance policy that was purchased – on or before March 23, 2010. Plans or policies may lose their 'grandfathered' status if they make certain significant changes that reduce benefits or increase costs to consumers."
[23] For more detail, see CHBRP's issue brief, *Essential Health Benefits: An Overview of Benefits, Benchmark Plan Options, and EHBs in California*.
[24] See CHBRP's resource, *Sources of Health Insurance in California*.

Background

As discussed in the *Introduction* section, AB 1032 would mandate reimbursement for up to 12 visits per year with a licensed behavioral health provider if an enrollee or insured is in a county where a local or state emergency has been declared due to wildfires. These benefits would apply until 1 year from the date the local or state emergency is lifted, whichever is later.

Behavioral health conditions broadly refer to both mental health conditions and substance use disorders (SUD), covering more than 300 specific conditions listed in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). Disorders range in severity, requiring differing levels of care and treatment. They can be acute or chronic, and newly induced or exacerbated via triggering events such as natural disasters. In general, chronic diseases of all types often involve cycles of recurrence and remission, can vary in severity, and often require ongoing professional treatment, lifestyle changes, and case management (ASAM, 2019; Goodwin and Sias, 2014). Certain behavioral health conditions, such as SUDs, are chronic conditions with both environmental and genetic influences (NIDA, 2023). People with SUDs often have periods of remission and relapse, and typically require long-term treatment consisting of multiple episodes of treatment over several years (Dennis and Scott, 2007; Saitz et al., 2008). This analysis addresses behavioral health, mental health, and SUD, using terms as they appear in the literature and as applicable to AB 1032.

Prevalence of Wildfires in California

Wildfires are unplanned fires that occur in wildland vegetation, and when uncontrolled, can damage structures in rural and urban areas. Wildfires in California have increased in frequency and caused more damage to land, structures, and people over the past few decades (Buechi et al., 2019). The past 10 years alone have seen some of the most destructive and deadliest fires in California history, including the 2018 Camp Fire and 2025 Eaton Fire (California Department of Forestry and Fire Protection, 2025; LAO, 2025). Data from FEMA place 31 counties in California at high or very high risk of hazards due to wildfires, 17 counties at moderate risk, and 10 counties at very low or relatively low risk, as shown in Figure 2 (FEMA, 2025). The risk index measures economic loss, social vulnerability, and community resilience in determining hazard levels due to wildfires.

Additionally, data from California's Department of Forestry and Fire Protection – which is required to map fire hazard within state responsibility areas based on fuel loading, slope fire weather, and other relevant factors – shows how areas prone to high or very high hazard from wildfires has grown 168% from 2011 (Christopher, 2025), accounting for land on which 3.7 million Californians reside.[25]

Figure 2. Risk Index for Wildfires, by County in California

Source: National Risk Index, FEMA, 2025.

Impact of Wildfires and Other Natural Disasters on Behavioral Health

Serious wildfires can result in harmful environmental conditions such as smoke and poor water quality, and disrupt residents' way of life through forced evacuations and burned or damaged property, land, and structures, as well as through the loss or fracture of jobs, income, social and community networks, and food and water security (LAO, 2025). On

[25] These maps make a distinction between state responsibility areas, local responsibility areas, and land under federal responsibility, which makes up 45% of land in California.

a more individual and short-term level, wildfires can disrupt daily routines for people with behavioral health conditions as well those without, and interfere with access to care, providers, facilities, and medications. Residents of an affected region can experience adverse physical and behavioral health conditions that last beyond the end of the fire. Such circumstances can cause or exacerbate COPD, sleep disorders, hypertension, mental health and substance use disorders, and more (Howard et al., 2021). Individuals who lose loved ones are at greater risk for serious psychological distress, which is a measure used to identify adolescents and adults with a high likelihood of having a diagnosable mental illness that impacts daily functioning.

It is well-documented that people surviving an array of natural disasters including hurricanes, earthquakes, tsunamis, and floods are more likely to experience behavioral health conditions after the end of the environmental event (Hrabok et al., 2020; Silveira et al., 2021; To et al., 2021). In current medical practice, the impact of a natural disaster on behavioral health is viewed in the same way as for other disaster events, including human-caused disasters, mass violence, or public health emergencies (National Center for PTSD, 2025a). Post-traumatic stress disorder (PTSD) is a common condition diagnosed among people directly experiencing or witnessing traumatic events, and is associated with symptoms lasting longer than four weeks, including severe anxiety, unwanted flashbacks or distressing memories, persistent negative thoughts, difficulty sleeping or concentrating, and certain physical reactions (National Center for PTSD, 2025c; North and Pfefferbaum, 2013). PTSD, depression, anxiety, acute stress disorder, complicated grief, sleeping disorders, and certain substance use disorders have been well documented to be prevalent following natural disasters, particularly among females, people who have prior or pre-existing psychiatric conditions, and those who are socioeconomically disadvantaged (Harada et al., 2015; Lowe et al., 2019; National Center for PTSD, 2025d; Norris et al., 2002; North and Pfefferbaum, 2013). Repeated exposure to catastrophic natural disasters is also associated with increased mental health symptoms (Garfin et al., 2022).

Prevalence of Behavioral Health Conditions Following Wildfires or Other Natural Disasters

Natural disasters like wildfires increase risk for certain behavioral health conditions, as explained above, and these conditions may persist over time. Longitudinal studies and expert medical opinion[26] suggest that certain behavioral health conditions reach their peak six months to 1 year following a disaster event, though results vary depending on the condition. PTSD may peak the first few months following the disaster and then decline, while depression and anxiety may persist over a longer time (Heanoy and Brown, 2024; Pietrzak et al., 2012b). Outcomes may also vary by adult or child population (Lai et al., 2021).

Adults

Following devastating Maui fires in 2023, over half (55%) of participants reported depressive symptoms (compared to both 38% of the general population and Maui residents in a prior survey); nearly one in three residents affected (30%) reported symptoms of moderate or severe anxiety; 35% reported low self-esteem; and 4.4% reported suicidal thoughts (Juarez et al., 2024). Such mental health conditions can persist long after the end of the natural event (Jenkins et al., 2009; Lowe et al., 2019; National Center for PTSD, 2025d; Pietrzak et al., 2012b).

Research on Canada's 2016 Fort McMurray fire, which forced evacuation of 88,000 individuals and destroyed 10% of homes, found that more than one-third (37.7%) of evacuees experienced the following clinically significant psychological symptoms 1 year later: insomnia disorder (28.5%), PTSD (15.4%), major depressive disorder (15%), generalized anxiety disorder (14.2%), and substance use disorder (7.9%) (Belleville et al., 2021). One in five individuals were likely to have two or more probable behavioral health diagnoses. Respondents who presented with likely PTSD were also significantly more likely to self-report increased drug abuse (but not increased alcohol use) after the fire.

Other studies examining the impact of this fire found variables associated with increased likelihood of PTSD and generalized anxiety disorder, respectively. Among evacuees with PTSD, females were more likely than males to have generalized anxiety disorder 6 months after the fire (14.9% and 8.7%, respectively). Women were also more likely to

[26] Content expert David Eisenman, MD, MSHS, suggests prevalence may peak six months to 1 year after a natural disaster event.

experience anxiety and depression longer than men after the wildfire, in part due to the financial challenges due to loss of a job and income. Predictors that were associated with an increased likelihood of generalized anxiety disorder symptoms included people who had a pre-existing anxiety disorder, witnessed homes being destroyed by the wildfire, lived in a different home after the wildfire, and received limited governmental support or limited family support (Agyapong et al., 2018).

With regard to SUD, data on the impact of natural disasters on substance use uptake or SUD prevalence is limited. Existing research often examines the prevalence of substance use among people with other mental health conditions. Studies suggest that the increased use of drugs including nicotine, alcohol, and other substances after a natural disaster alongside co-existing substance use may lead to poorer health outcomes (Fergusson et al., 2014; Shuler et al., 2017).

Youth

Wildfires also impact the mental health of children and adolescents, with youth experiencing higher rates of anxiety and mood disorders compared to adults (Adu et al., 2023; Brown et al., 2019). Children also experience changes in concentration, sleep, behavior, and academic performance (Brown et al., 2019; NCTSN, 2010). In a study of the impacts of the Canadian Fort McMurray fire on children, nearly half (46%) of children grades 7 to 12 – including those who were not present at Fort McMurray at the time of the fire – met criteria for probable diagnosis of PTSD, depression, anxiety, or substance use 18 months after the fire. When compared with children in a comparable region that was unaffected by the fire, the impacted population of children still exhibited statistically significantly different behavioral health symptoms and substance use, including depression (31% vs. 17%), moderately severe depression (17% vs. 9%), suicidal thinking (16% vs. 4%), and tobacco use (13% vs. 10%). Rates of anxiety and alcohol or other substance use were similar.

Demand in Mental Health Care

The increased utilization of mental health care and medications following a wildfire and smoke events demonstrate the increased need for mental health services in the period following the event. Emergency department visits for anxiety increased due to wildfires on the U.S. West Coast, particularly among women, girls, and older adults (Zhu et al., 2024). Short-term exposure to smoke events from wildfires in California also are associated with increased emergency department visits for schizophrenia (Chen et al., 2023).

As one example, a study examining 25 major California wildfires from 2011 to 2018 found an increase in psychotropic medication use among individuals living in areas affected by the fire compared to before the fire, specifically for antidepressants, anxiolytics, and mood-stabilizing medications (Wettstein and Vaidyanathan, 2024).[27] Another study found that emergency department use for anxiety disorders increased due to wildfires.

Another study examining calls to the 988 Suicide and Crisis Lifeline in Hawaii after the Maui 2023 wildfires that destroyed the town of Lahaina found a statistically significant increase in the number of calls to the hotline after the wildfire. There were positive and substantial lag times in the 9 to 12 months after the wildfire, suggesting that need increased and was sustained after the wildfire (Rivera-González et al., 2024).

Disparities

Disparities are noticeable and preventable or modifiable differences between groups of people. Health insurance benefit mandates or related legislation may impact disparities. Where intersections between health insurance benefit mandates and social determinants or systemic factors exist, CHBRP describes relevant literature.

In addition to the groups mentioned above (i.e., women, girls, socioeconomically disadvantaged populations), there are disparities in prevalence of mental health conditions before and after natural disaster (Lowe et al., 2019).

[27] There were no statistically significant differences in prescription of psychotics, hypnotics, or statins before and after the fire (Wettstein and Vaidyanathan, 2024).

- Individuals who are unhoused already experience significantly higher rates of mental health conditions and substance use (Kushel et al., 2023).

- Black and Hispanic populations are more likely to experience adverse mental health outcomes after natural disasters in the U.S., as evidenced after multiple disaster events (Berberian et al., 2022).

- Older adults are more likely to have increased need for mental health services as well as high prevalence of stress, anxiety, insomnia, PTSD, depression, and fear of death postdisaster (Corley et al., 2022; Seritan, 2023; Sirey et al., 2017; Swiatek et al., 2021; Zhu et al., 2024). In research on the impact of the Maui wildfires, depression prevalence increased with age, peaking at 75% for those between 50 and 59 years (Juarez et al., 2024). Among older individuals, pre-existing psychological conditions were associated with a greater need for mental health care (Pietrzak et al., 2012a). Similar to findings for the younger community, the presence and strength of a larger social network and community support system are associated with a reduction in the psychological impact of a disaster (Heid et al., 2016).

- Rural residence, low income, and fewer years of education are associated with increased risk of severe mental illness, while employment is associated with decreased risk of serious mental illness (Stukova et al., 2023).

- Farmworkers report having to work through poor air quality and smoke caused by wildfires in California (University of California Merced Community and Labor Center, 2023). In similar wildfire season and smoke conditions in Washington state, farm workers report struggling with their own mental health as well as concern for their children during smoke events (D'Evelyn et al., 2024).

Treatments of Behavioral Health Disorders and Unmet Need

Common Behavioral Health Treatments

There are many different types of behavioral health treatments, of varying levels of care, visit lengths, in both inpatient and outpatient settings, and in-person or telehealth. For the purposes of this bill, the focus is on individual and group treatment, provided in outpatient settings such as provider offices or clinics, or virtually. Below, common treatments such as cognitive behavioral therapy (CBT) and eye movement desensitization and reprocessing (EMDR) are described.

Individual therapy

Individual therapy involves one-on-one sessions between a licensed behavioral health provider and a patient. These psychotherapy visits can include services such as evaluation and management, screenings, assessments, diagnoses, and medication management, depending on the type of provider, type and purpose of the visit, and patient need. Common evidence-based treatments provided to people with behavioral health conditions triggered by disaster events or other traumatic events include CBT, EMDR, exposure therapy, and psychopharmacology (see the *Medical Effectiveness* section for details on the evidence). CBT is a form of treatment commonly used to treat depression, anxiety disorders, PTSD, alcohol and drug use, severe mental illness, and more. Research on CBT is extensive, and findings suggest it can lead to a significant improvement in functioning and quality of life, in some cases even compared to psychiatric medications (APA, 2017b). Certain types of CBT are specifically geared to reduce symptoms of PTSD and trauma (APA, 2017b), including cognitive processing therapy and exposure therapy. EMDR is conditionally recommended for the treatment of PTSD and/or other disorders to help patients process trauma and reduce symptoms. The treatment integrates bilateral stimulation (often eye movements) to reprocess traumatic memories and reduce associated distress. The treatment typically is delivered over 6 to 12 sessions (APA, 2023).

Many treatments can be delivered by a range of licensed behavioral health providers, while psychopharmacology treatment can only be provided by certain licensed providers, including psychiatrists, and in some states, psychologists

who are licensed to prescribe psychotropic medications (APA, 2022).[28] Pharmacotherapy encompasses psychopharmacology, which refers to the use of psychotropic medications to treat behavioral health conditions. Psychopharmacology can be an effective tool on its own or in concert with psychotherapy. Drug classes such as selective serotonin reuptake inhibitors are often used to treat depression but also have uses for PTSD and anxiety (National Center for PTSD, 2025b). The type of medication prescribed depends on a variety of factors including patient need, condition, and possible contraindications with other medication use.

Group therapy

Group therapy involves a small group of individuals with the same or similar condition receiving treatment under a licensed behavioral health provider. These groups differ from support groups, which can be peer led. Groups can be designed to target a specific problem, such as alcohol or substance use, depression, panic disorder, anxiety, obesity, among others, or can be more general. They emphasize mutual support, feedback, and social learning. The length and timing of sessions can vary, but are typically once or twice a week for 1 hour, with varying timelines depending on the focus.

CHBRP interprets AB 1032 to apply generally to outpatient behavioral health treatments provided by licensed behavioral health providers; other types of treatments including intensive outpatient programs, inpatient therapy, and residential treatment programs are not a focus for this analysis. For detailed information on treatment types and settings for behavioral health, please refer to the Abbreviated Analysis of California AB 1451 published by CHBRP in 2023. For detailed information on substance use disorders, treatment rates, and more, please refer to the Analysis of California SB 11 published by CHBRP in 2020.

Unmet Need

In 2023, nearly 4 in 10 (39.5%) people 12 years and older reported that they delayed or did not get needed mental health care in the past 12 months (CHIS, 2023). In general, among Californians who report that they do not get needed care, roughly one-third report cost as the reason (CHIS, 2023).

In 2023, 11.2% of California children ages 3 to 17 years were reported to have received any mental health care or counseling from a mental health professional in the past 12 months. Among those reporting they did not receive mental health care from a professional, 53.7% reported the reason being that it was somewhat or very difficult or impossible to get care.

Regarding substance use specifically, 8.8% of Californians 12 years and older met the criteria for a SUD in the past year during a 2018 to 2019 time period (CHCF, 2022b). Of the population12 years and older in California, 6.3% met the criteria for alcohol misuse or dependence, and 3.6% for illicit drug abuse and dependence (SAMHSA, 2025).

Need during disasters or wildfires

Unexpected major disasters could increase demand for behavioral health care. Data on Project Liberty, a public health program that provided free educational and counseling services after the September 11 terrorist attacks, saw 250,000 calls for crisis counseling in the first 6 months, the same number as for all mental health clinic programs in a prior year (Siegel et al., 2004). On Maui during the July 2022 to August 2024 period, monthly 988 Suicide and Crisis Lifeline calls routed to a Hawai'i call center ranged from 1,018 to 2,277 (Rivera-González, et al, 2024). The call rate increased from a monthly mean of 97.5 calls per 100,000 Hawai'i residents during the pre-wildfire period (prior to August 2023) to 137.4 calls per 100,000 residents in the post-wildfire period. Positive and substantial lag times were detected for months 9 to 12

[28] Under AB 1032, visits to primary care physicians – who commonly prescribe certain psychotropic medications – would not be eligible for reimbursement, but visits to licensed behavioral health providers such as psychiatrists for the purposes of pharmacotherapy would be eligible for reimbursement for people residing in counties with local or state emergency declarations due to wildfires.

post wildfire, suggesting a sustained increase in call volume following the disaster. The increase in 988 calls highlight the increased demand for mental health services after the wildfire.

One research study in California on the impact of the 2017 Tubbs, Atlas, Nuns, and Pocket fires found that there was a reported need for professional care or general support for mental health immediately following a wildfire, as well as at the time of survey (4–9 months after the wildfires). A persistent need for mental health care was more likely than a persistent need for categories of goods or lifestyle needs, and of the households reporting health impacts, the majority were for mental health such as anxiety and trauma. Importantly, according to the study, the need for mental health extends for years after the wildfires; the crisis counseling service CalHOPE Sonoma continued to receive calls from people needing mental health services for several years after the wildfires (Snyder et al., 2025).

Network adequacy and unmet need

Research shows that provider directories, particularly for plans offered through Covered California, can have inaccurate information on participating behavioral health providers, leading to barriers to timely urgent care and general appointments (Burman, 2023). National data from a survey of psychologists shows that one-third (34%) do not contract with insurers (APA, 2025). In California, DMHC in 2023 fined Kaiser Permanente $50 million for lack of adequately timely care to behavioral health services (DMHC, 2023).

Mental Health Workforce in California

Coverage does not guarantee access to care for behavioral health. Access is also affected by the supply of providers. Patients report a variety of challenges in accessing needed or preferred behavioral health providers, as well as dissatisfaction with their insurance in the availability of mental health providers (Panchal and Lo, 2024). The California Health Care Foundation reported that there were nearly 100,000 mental health professionals in California in 2020, unevenly distributed across the state (measured by per capita ratios) (CHCF, 2022a). Professionals include psychologists, psychiatrists, professional clinical counselors, marriage and family therapists, clinical social workers, and psychiatric technicians. The distribution of different professionals by county varies drastically per 100,000 population. For example, the San Joaquin Valley and Inland Empire had supplies per capita that were far below the state per capita average ratio across all professions except psychiatric technicians.

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Medical Effectiveness

As discussed in the *Introduction* section, AB 1032 would mandate reimbursement for up to 12 visits per year with a licensed behavioral health provider if an enrollee or insured is in a county where a local or state emergency has been declared due to wildfires. These benefits would apply until 1 year from the date the local or state emergency is lifted, whichever is later.

The medical effectiveness review summarizes findings from evidence[29] on the impact of visits with licensed behavioral health providers on the following behavioral health conditions generally and when they are rooted in experience with any kind of natural disaster: post-traumatic stress disorder (PTSD), depression, anxiety, substance use disorder (SUD), and sleep disturbances. Services provided by the following behavioral health providers are assumed to be covered by AB 1032:

- Psychiatrists
- Psychologists
- Providers regulated by the Board of Behavioral Sciences at the California Department of Consumer Affairs:
    - Licensed Marriage and Family Therapists (LMFT) and Associates
    - Licensed Clinical Social Workers (LCSW) and Associates
    - Licensed Professional Clinical Counselors (LPCC) and Associates
    - Licensed Educational Psychologists.

Research Approach and Methods

The search was limited to studies published from 2015 to the present. CHBRP identified one scoping review published in 2021 (Le Roux and Cobham, 2021) and one meta-analysis published in 2024 (Xie et al., 2024) that identified some older studies that were pertinent to the analysis of AB 1032. A total of five articles published between 2002 and 2011 identified in the scoping review and meta-analysis were included in this medical effectiveness review for this report (Chemtob et al., 2002a, 2002b; Hamblen et al., 2009; Jaycox et al., 2010; Taylor and Weems, 2011).[30]

A total of 21 studies were included in the medical effectiveness review for this report. The other articles were eliminated because natural disasters took place in countries other than the United States, interventions were web-based, or interventions were provided via a different model of care (e.g., walk-in counseling services) than what AB 1032 would require health plans to cover. A more thorough description of the methods used to conduct the medical effectiveness review and the process used to grade the evidence for each outcome measure is presented in CHBRP's Medical Effectiveness Analysis and Research Approach document.

[29] Much of the discussion in this section is focused on reviews of available literature. However, as noted in the section on Implementing the Hierarchy of Evidence in the Medical Effectiveness Analysis and Research Approach document, in the absence of fully applicable to the analysis peer-reviewed literature on well-designed randomized controlled trials (RCTs), CHBRP's hierarchy of evidence allows for the inclusion of other evidence.

[30] Studies of the effects of visits with behavioral health providers were identified through searches of PubMed and Embase. Websites maintained by the following organizations were also searched: AHRQ, NICE, SIGN, SAMHSA, USPSTF, and WHO. The search was limited to abstracts of studies published in English from 2015 to the present.

The conclusions below are based on the best available evidence from peer-reviewed and grey literature.[31] Unpublished studies are not reviewed because the results of such studies, if they exist, cannot be obtained within the 60-day timeframe for CHBRP reports.

Key Questions

1. For people experiencing behavioral health conditions common among people exposed to natural disasters (PTSD, depression, anxiety, SUD, or sleep disturbances) due to any form of trauma, what is the impact of visits with a licensed behavioral health provider on reducing the symptoms of the experienced behavioral health condition compared with no intervention?
2. Among people who live in an area affected by a natural disaster (wildfires, hurricanes/tropical storms, tsunamis, floods, mudslides, earthquakes, tornadoes), what is the impact of visits with a licensed behavioral health provider on reducing the effects of behavioral health conditions rooted in experience with a natural disaster (PTSD, depression, anxiety, SUD, sleep disturbances) compared with no intervention?

Methodological Considerations

CHBRP did not conduct a full-scale review of the effectiveness of psychotherapy or pharmacotherapy for treating behavioral health conditions common among people exposed to natural disasters when those conditions are not rooted in experiences with natural disasters. A full-scale review was not conducted because there is a substantial body of literature indicating that psychotherapies and pharmacotherapies are effective treatments for these conditions. CHBRP conducted a full-scale review of the effectiveness of psychotherapies and pharmacotherapies for treating PTSD, anxiety, depression, SUD, and sleep disturbances when rooted in experience with natural disasters and considers this literature complementary to the established research on general trauma care treatments for these behavioral health conditions.

Among the six studies included in this medical effectiveness review that focus on people who experienced a natural disaster, none of the literature pertains to people who have experienced wildfires. The second research question was expanded to include evidence about the impact of visits with behavioral health providers among people who had experienced any kind of natural disaster in anticipation of the dearth of literature relative to wildfires. All six studies involved people who experienced hurricanes; two articles assessed the impact of behavioral health visits with survivors of Hurricane Iniki on the Hawaiian island of Kauai (Chemtob et al., 2002a, 2002b); three articles assessed the impact of behavioral health visits with survivors of Hurricane Katrina in New Orleans, Louisiana (Goldman et al., 2015; Jaycox et al., 2010; Taylor and Weems, 2011); and one article assessed the impact of behavioral health visits with survivors of Hurricane Katrina or Hurricane Rita in Baton Rouge, Louisiana (Hamblen et al., 2009). Five of the six identified articles assessed the impact of behavioral health visits on children and had interventions that were delivered in a school-based setting (Chemtob et al., 2002a, 2002b; Goldman et al., 2015; Jaycox et al., 2010; Taylor and Weems, 2011). Only one article assessed the impact of behavioral health visits on adults (Hamblen et al., 2009). None of the studies specified whether the behavioral health professionals who provided the intervention were licensed. These articles were included in this medical effectiveness analysis because the types of services that the behavioral health professionals provided are typically provided by licensed professionals. Lastly, only one randomized controlled trial (RCT) was identified and included in this medical effectiveness review (Chemtob et al., 2002b).

[31] Grey literature consists of material that is not published commercially or indexed systematically in bibliographic databases. See CHBRP's website for more information.

Outcomes Assessed

CHBRP assessed:

- The impact of *psychotherapy* treatments for behavioral health conditions *common among* people exposed to natural disasters
- The impact of *pharmacotherapy* treatments for behavioral health conditions *common among* people exposed to natural disasters
- The impact of *psychotherapy* treatments for behavioral health conditions *experienced by* people exposed to a natural disaster
    - The impact of psychosocial treatment on children
    - The impact of eye movement desensitization and reprocessing treatment (EMDR) on children
    - The impact of cognitive behavioral therapy (CBT) on children
    - The impact of CBT on adults
- The impact of *pharmacotherapy* treatments for behavioral health conditions *experienced by* people exposed to a natural disaster

Study Findings

The following section summarizes CHBRP's findings regarding the strength of evidence for the effectiveness of visits with licensed behavioral health providers and pharmacotherapy on behavioral health conditions as part of general trauma care and when rooted in experience with a natural disaster addressed by AB 1032. Each section is accompanied by a corresponding figure. The title of the figure indicates the test, treatment, or service for which evidence is summarized. The statement in the box above the figure presents CHBRP's conclusion regarding the strength of evidence about the effect of a particular test, treatment, or service based on a specific relevant outcome and the number of studies on which CHBRP's conclusion is based. Definitions of CHBRP's grading scale terms are included in the box below.

The following terms are used to characterize the body of evidence regarding an outcome:

Very strong evidence indicates that there are multiple studies of a treatment and the large majority of studies are of high quality and consistently find that the treatment is either effective or not effective. Conclusions are unlikely to be altered by additional evidence.

Strong evidence indicates that the majority of the studies reviewed are consistent in their findings that treatment is either effective or not effective. Conclusions could be altered with additional strong evidence.

Some evidence indicates that a small number of studies have limited generalizability to the population of interest and/or the studies have a serious methodological concern in research design or implementation. Conclusions could be altered with additional evidence.

Conflicting evidence indicates that a similar number of studies of equal quality suggest the treatment is effective as suggest the treatment is not effective.

Not enough research indicates that there are no studies of the treatment or the available studies are not of high quality, meaning there is not enough evidence available to know whether or not a treatment is effective. It does not indicate that a treatment is not effective.

Effectiveness of Psychotherapy Treatment for Behavioral Health Conditions Common Among People Exposed to Natural Disasters

This section summarizes findings from systematic reviews and meta-analyses about the effectiveness of psychotherapy treatments for PTSD, depression, anxiety, SUD, and sleep disturbances as part of general trauma care. This section focuses on two common types of psychotherapies, CBT (including exposure-based therapy) and EMDR, because evidence was identified for these treatments among people experiencing behavioral health conditions rooted in a natural disaster. The most robust body of literature exists for PTSD. One systematic review (North and Pfefferbaum, 2013) demonstrated that there is very strong evidence that CBT is an effective treatment, and three meta-analyses (Bradley et al., 2005; Lewis et al., 2020; Van Etten and Taylor, 1998) demonstrated that there is very strong evidence that CBT and EMDR are effective treatments for PTSD. North and Pfefferbaum also demonstrated strong evidence that CBT is effective at treating depression, and one systematic review demonstrated some preliminary evidence that EMDR is effective at treating depression (Valiente-Gomez et al., 2017). One meta-analysis (Norton and Price, 2007) cites many other meta-analyses demonstrating strong evidence that CBT is effective for treating a range of anxiety disorders, and Valiente-Gomez et al. identified four RCTs that demonstrated that EMDR had a positive effect on anxious and obsessive-compulsive disorder symptoms. One meta-analysis of RCTs reported small but statistically significant effects of CBT on SUD, where the effects of CBT were largest in marijuana studies (Magill and Ray, 2009), and Valiente-Gomez et al. identified one study that demonstrated that EMDR had a statistically significant, positive effect on obsessive compulsive drinking behaviors. There was less evidence that psychotherapy was effective for treating sleep disturbances. One meta-analysis demonstrated that CBT was effective in treating insomnia (van Straten et al., 2018). CHBRP did not identify any systematic reviews or meta-analyses demonstrating that EMDR is an effective treatment for sleep disturbances.

Summary of findings regarding psychotherapy treatments for behavioral health conditions common among people exposed to natural disasters: There is a robust body of literature demonstrating that psychotherapies, specifically CBT and EMDR, are effective for treating behavioral health conditions commonly experienced by people who have been exposed to a natural disaster. There is very strong evidence that CBT and EMDR are effective at treating PTSD, strong evidence that CBT and EMDR are effective for treating depression, very strong evidence that CBT and EMDR are effective at treating anxiety, some evidence that CBT and EMDR are effective at treating SUD, and some evidence that CBT is effective at treating sleep disturbances, based on eight studies.

Figure 3. Evidence of Effectiveness of Psychotherapy for PTSD

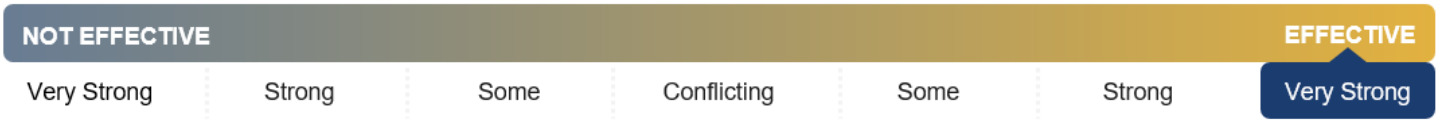


Figure 4. Evidence of Effectiveness of Psychotherapy for Depression

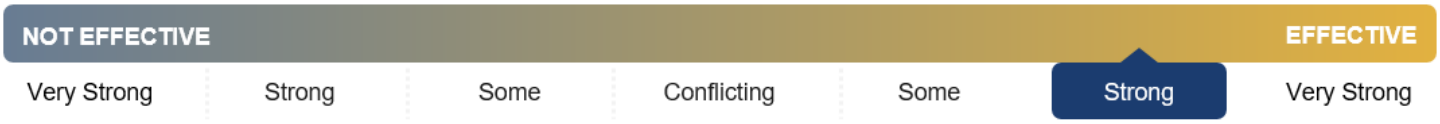


Figure 5. Evidence of Effectiveness of Psychotherapy for Anxiety

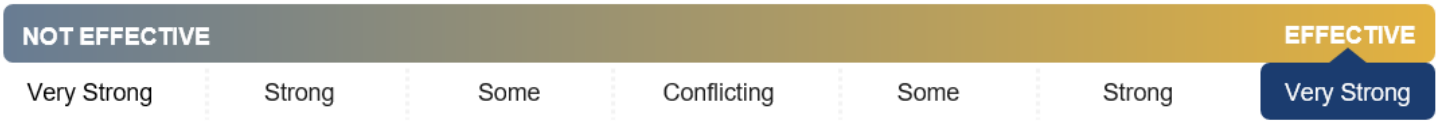


Figure 6. Evidence of Effectiveness of Psychotherapy for SUD

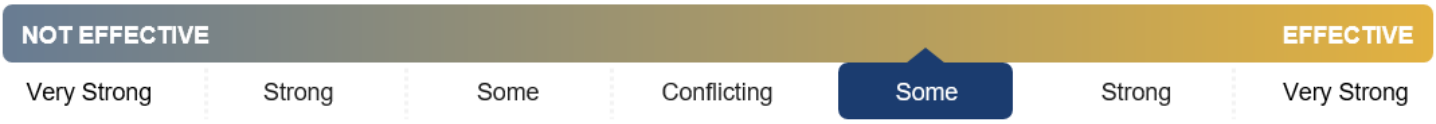


Figure 7. Evidence of Effectiveness of Psychotherapy for Sleep Disturbances

Effectiveness of Pharmacotherapy Treatment for Behavioral Health Conditions Common Among People Exposed to Natural Disasters

This section summarizes findings from systematic reviews and meta-analyses about the effectiveness of pharmacotherapy treatments for PTSD, depression, anxiety, SUD, and sleep disturbances as part of general trauma care. One systematic review (North and Pfefferbaum, 2013) demonstrated that antidepressants and adjunctive medications are effective treatments for PTSD, and one meta-analysis (Hoskins et al., 2015) demonstrated that a specific type of antidepressant called selective serotonin reuptake inhibitors was effective at reducing PTSD symptoms, although the effect size for the latter study was small. North and Pfefferbaum (2013) also demonstrated that antidepressants and adjunctive medications are effective treatments for depression, and one meta-analysis (Cipriani et al., 2018) revealed modest effect sizes for a range of antidepressants to treat depression. Two meta-analyses (Bandelow et al., 2015; Slee et al., 2019) demonstrated that a variety of medications are effective for treating anxiety but that the best treatment option might not be the same for all people due to individual patient differences; one study (Slee et al., 2019) focused on medications for generalized anxiety disorder, and the other study (Bandelow et al., 2015) assessed medication effectiveness for generalized anxiety disorder, panic disorder, and social phobia. One systematic review (Mateu-Mollá et al., 2025) evaluated the effectiveness of various pharmacological treatments for SUD, including alcohol, tobacco, cannabis, stimulant, and opioid use disorder; the authors found that a wide variety of medications can be used to clinically manage these conditions but that pharmacological treatments for alcohol use disorder were studied most extensively. Two meta-analyses (Buscemi et al., 2007; Yue et al., 2023) demonstrated that medications can effectively treat insomnia. Yue et al. (2023) found that several types of drugs could treat insomnia but recommended orexin receptor agonists from an efficacy and safety perspective. Buscemi et al. (2007) focused on chronic insomnia and found that benzodiazepines, non-benzodiazepines, and antidepressants are effective treatments for chronic insomnia.

Summary of findings regarding pharmacotherapy treatment for behavioral health conditions common among people exposed to natural disasters: There is a robust body of literature demonstrating that pharmacotherapy is effective for treating behavioral health conditions commonly experienced by people who have been exposed to a natural disaster. The medications recommended to treat these behavioral health conditions vary widely. There is strong evidence that pharmacotherapy is effective at treating PTSD, strong evidence that pharmacotherapy is effective at treating depression, strong evidence that pharmacotherapy is effective at treating anxiety, some evidence that pharmacotherapy is effective at treating SUD, and strong evidence that pharmacotherapy is effective at treating sleep disturbances, based on eight studies.

Figure 8. Evidence of Effectiveness of Pharmacotherapy for PTSD

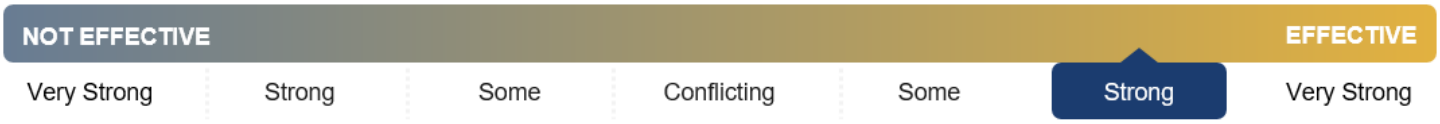


Figure 9. Evidence of Effectiveness of Pharmacotherapy for Depression

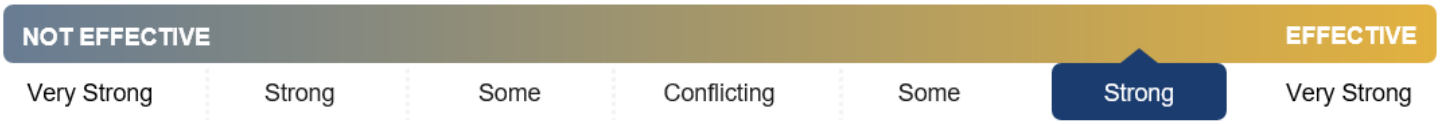


Figure 10. Evidence of Effectiveness of Pharmacotherapy for Anxiety

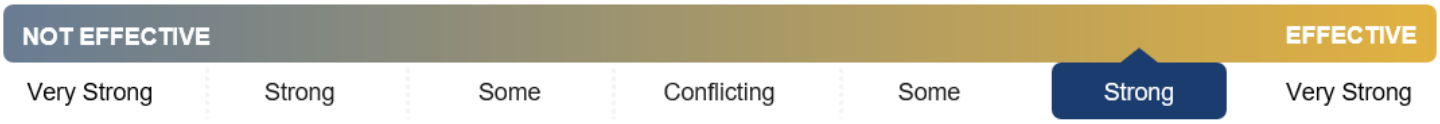
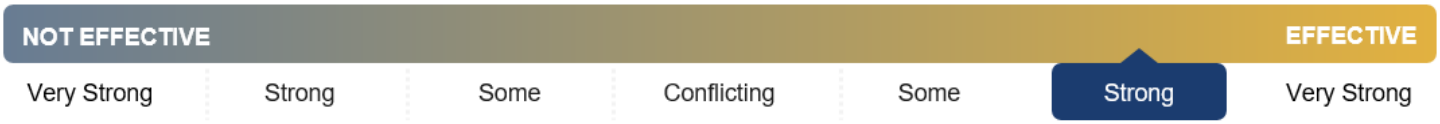


Figure 11. Evidence of Effectiveness of Pharmacotherapy for SUD

Figure 12. Evidence of Effectiveness of Pharmacotherapy for Sleep Disturbances



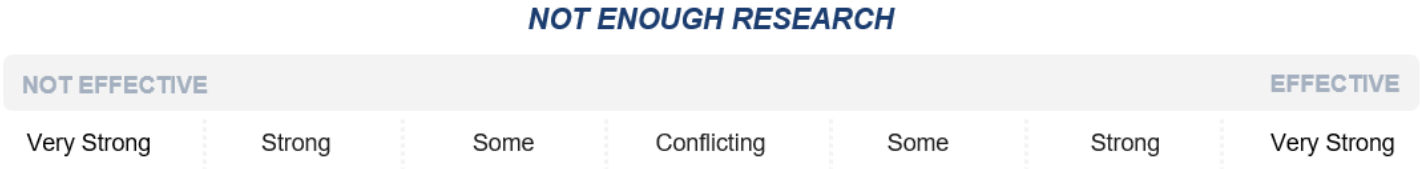
Effectiveness of Psychotherapy Treatment for People Exposed to Natural Disasters

Effectiveness of psychosocial treatment for children

CHBRP identified one RCT study that assessed the efficacy of psychosocial treatment for trauma symptoms for children in second through sixth grade attending school at any of the 10 public elementary schools on the Hawaiian island of Kauai 2 years after Hurricane Iniki (Chemtob et al., 2002b). Children (mean age 8.22 years among treatment completers) were grouped into one of three consecutively treated cohorts, where children with the highest levels of trauma-related symptoms received treatment first. Children assigned to one of the cohorts awaiting treatment served as wait-list controls. Within each cohort, children were randomly assigned to receive either group (n = 176) or individual (n = 73) treatment. Separate manuals for group treatment and individual treatment were created to appropriately treat the study's population. Similar activities were used in both treatments, but children in group treatment engaged in cooperative play and discussion. Treatment was provided by specially trained school-based counselors, one of whom was a clinical social worker, and consisted of four weekly sessions. Trauma symptoms were measured using the Kauai Recovery Inventory (KRI), a 24-item self-report measure, and the Child PTSD Reaction Index (CRI), a clinician-administered semi-structured interview for evaluating PTSD symptoms. According to data collected in the KRI, there was a statistically significant reduction in trauma symptoms from pretreatment to posttreatment for children who participated in individual treatment and group treatment. The effect size for this reduction was 0.50, indicating a noticeable improvement in trauma symptoms about halfway between a small change and big change. No significant main effects were found for the treatment cohort or treatment type (individual vs group), but children were significantly more likely to complete group treatment than individual treatment. Treated children had significantly lower CRI scores (mean score = 11.65) compared to untreated children (mean score = 20.32); the effect size was 0.76. The significant reduction in KRI scores between pretreatment and posttreatment was maintained at the 1-year follow-up, indicating sustained symptom reduction.

Summary of findings regarding psychosocial treatment for children: There is not enough research that psychosocial treatment for children is effective at reducing trauma symptoms based on one study (Chemtob et al., 2002b). This study found statistically significant improvement in trauma symptoms for participants of individual treatment and participants of group treatment, but participants were more likely to complete group treatment. CHBRP did not identify any studies that addressed the impact of CBT on SUD or sleep disturbances.

Figure 13. Evidence of Effectiveness of Psychosocial Treatment for Children

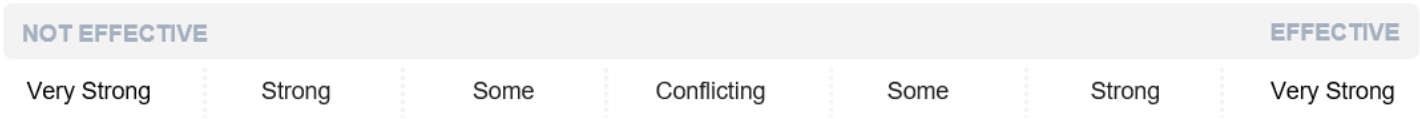


Effectiveness of eye movement desensitization and reprocessing treatment for children

CHBRP identified one controlled study (Chemtob et al., 2002a) that assessed the impact of EMDR treatment on children with PTSD who had experienced Hurricane Iniki. This was a follow-on study to the previously described study (Chemtob et al., 2002b). Chemtob et al., 2002a reported on treated participants (n = 32) who did not respond to previous treatment, met the criteria for disaster-related PTSD, and for whom parental consent for treatment could be obtained. Study participants attended seven schools representing every island region in Kauai and were placed into two groups; Group 1 included the students who received treatment immediately (n = 17), and Group 2 included waitlisted students who received delayed treatment (n=15). Doctoral-level clinicians provided treatment sessions weekly at the child's school. Information about EMDR treatment can be found in the *Background* section. Like Chemtob et al., 2002b, this study also used the CRI to measure PTSD symptoms. On average, Group 1 showed decreased CRI scores by 54.93% at posttreatment, and Group 2 showed decreased CRI scores by 42.93% at posttreatment. These decreased levels were maintained at six-month follow-up; on average, Group 1 showed decreased CRI scores by 71.0% at follow-up, and Group 2 showed decreased CRI scores by 52.3% at follow-up. The Revised Children's Manifest Anxiety Scale and the Children's Depression Inventory were also used to measure anxiety and depression, respectively. Although less dramatic, participants in both groups also showed statistically significant reductions in anxiety and depression.

Summary of findings regarding EMDR treatment for children: There is *not enough research* that EMDR treatment is effective at reducing PTSD, anxiety, and depression for children based on one study (Chemtob et al., 2002a). This study found statistically significant improvement in study participant PTSD, anxiety, and depression, but no other studies were identified. CHBRP did not identify any studies that addressed the impact of EMDR on SUD or sleep disturbances.

Figure 14. Evidence of Effectiveness of EMDR Treatment for Children



Effectiveness of cognitive behavioral therapy for children

CHBRP identified three studies that assessed the impact of different variations of cognitive behavioral therapy (CBT) on children who had been exposed to Hurricane Katrina (Goldman et al., 2015; Jaycox et al., 2010; Taylor and Weems, 2011).

One field trial assessed the impact of two interventions, Cognitive-Behavioral Intervention for Trauma in Schools (CBITS) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), on children suffering from PTSD and depression after exposure to Hurricane Katrina (Jaycox et al., 2010). Children (n=71) in fourth through eighth grade at three schools in New Orleans 15 months after hurricane exposure were randomly assigned to one of the two intervention groups. There was no control group in this study. CBITS is a 10-group session and one to three individual session intervention designed specifically for use in schools, and TF-CBT is a 12-session individual or conjoint intervention that includes the child and their parents and typically is delivered in clinics. Both CBITS and TF-CBT include cognitive-behavioral skills, including psychoeducation, relaxation skills, affective modulation skills, cognitive coping skills, trauma narrative, in vivo mastery of

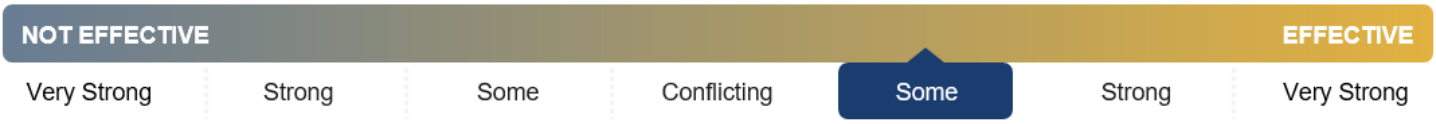
trauma reminders, and enhancing safety. One major difference between the two interventions is that TF-CBT is conducted with the child and their parents while CBITS is provided in a group format with children only. Treatment was provided by therapists who received training from the developers of the treatment models. Among children in the CBITS treatment group (n = 57), mean PTSD and depression scores 10 months after baseline measurements decreased by 4.85 and 4.3 points, respectively; these findings were statistically significant. Among children in the TF-CBT treatment group (n = 14), mean PTSD and depression scores 10 months after baseline measurements had been taken decreased by 3.07 and 1.37 points, respectively. These decreases were less dramatic compared to students who participated in CBITS, and only the decreased PTSD scores for students who participated in TF-CBT were statistically significant. After treatment, 65% of participants in the CBITS group remained in the "at risk" range for PTSD, and 45% of participants in the TF-CBT group remained in the "at risk" range for PTSD.

One study assessed the impact of an intervention called the School Therapeutic Enhancement Program (STEP) on children suffering from depression or who were exhibiting disruptive behaviors 1 year after Hurricane Katrina (Goldman et al., 2015). Children (n = 386) attending one of 14 elementary, 13 middle, and 9 high schools in Jefferson Parish, a suburban community of New Orleans, were assigned to one of two intervention groups: depression or disruptive behavior. A group of students (n = 986), screened across the entire Jefferson Parish district, who had high mental health need scores but did not receive STEP treatment served as the comparison group. However, there were age, gender, and racial differences between the comparison and intervention groups. The STEP depression treatment was an adaptation of "The ACTION Treatment Program," a program focused on evidence-based CBT for depression, and the STEP disruptive behavior treatment was an adaptation of the "Coping Power" program, an evidence-based CBT intervention for disruptive youth. Children's emotional and behavioral symptoms were measured using the Strengths and Difficulties Questionnaire, a 25-item checklist, to assess overall distress. Additionally, children's ADHD and Oppositional Defiant symptoms were measured using the Swanson, Nolan, and Pelham Questionnaire-4th edition (SNAP-IV) consisting of 26 questions, and children's depression symptoms were measured using the Beck Depression Inventory – Youth, a 20-item self-report inventory. All participants in either the depression or disruptive behavior STEP intervention groups showed a statistically significant decrease in mean Strengths and Difficulties Questionnaire Total Difficulties from 23.7 to 15.93. High-need students who participated in one of the intervention groups showed statistically significant drops in their mean Beck Depression Inventory – Youth scores (73.0 to 55.0). Among high-need students, caregivers and teachers administering SNAP-IV indicated statistically significant declines in inattention, hyperactivity, and oppositional defiant disorder. However, only the declines in inattention were clinically significant.

One multiple baseline study assessed the efficacy of the StArT manual, a trauma-focused CBT for hurricane-exposed youth, on reducing PTSD diagnoses and symptoms (Taylor and Weems, 2011). The StArT treatment is a therapist-guided protocol that is a manual-based intervention comprised of 10 sessions lasting approximately one hour and consists of five main components: psychoeducation, cognitive restructuring, exposure, problem-solving, and relapse prevention. Study participants included students ages 8 to 13 years (n = 6) at a public school in New Orleans who were exposed to Hurricane Katrina and/or its aftermath. PTSD symptoms were measured using the Reaction Index for Children. Pretreatment, all study participants had a PTSD diagnosis. At posttreatment, no study participants had a PTSD diagnosis. Additionally, all study participants reported reductions in PTSD-Reaction Index for Children scores. The Anxiety Control Questionnaire for Children was used to measure anxiety, and the authors did not find statistically significant differences in participant scores from pretreatment to posttreatment.

Summary of findings regarding CBT for children: There is some evidence that CBT for children is effective at reducing PTSD diagnoses, PTSD symptoms, depression, and anxiety based on three studies (Goldman et al., 2015; Jaycox et al., 2010; Taylor and Weems, 2011). One study found reductions in PTSD diagnoses (Taylor and Weems, 2011), two studies found significant reductions in PTSD symptoms (Jaycox et al., 2010; Taylor and Weems, 2011), two studies found significant reductions in depression symptoms (Goldman et al., 2015; Jaycox et al., 2010), and two studies found significant reductions in anxiety symptoms (Goldman et al., 2015; Taylor and Weems, 2011). One study had a notably small sample size (n = 6) (Taylor and Weems, 2011), and only one study had a comparison group (Goldman et al., 2015). CHBRP did not identify any studies that addressed the impact of CBT on SUD or sleep disturbances.

Figure 15. Evidence of Effectiveness of Cognitive Behavioral Therapy for Children

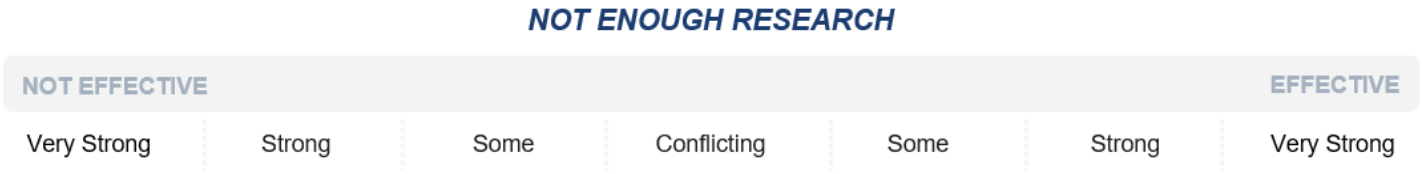


Effectiveness of CBT for adults

CHBRP identified one quasi-experimental time-series study that assessed the impact of CBT for postdisaster distress (CBT-PD) on adults living in the greater Baton Rouge area who had been exposed to either Hurricane Katrina or Hurricane Rita (Hamblen et al., 2009). The CBT-PD intervention was focused on identifying and challenging maladaptive disaster-related beliefs. CBT-PD was delivered 16 months postdisaster and included four components: psychoeducation, breathing retraining, behavioral activation, and cognitive restructuring. Therapists who delivered CBT-PD included psychologists, professional counselors, and clinical social workers. All therapists were required to show proof of license and insurance and to hold at least a master's degree in a mental health field. Participants (n = 88) who provided complete data (data for all four repeated assessments at referral, pretreatment, intermediate, and posttreatment) were considered the primary analysis sample. Intention-to-treat analyses of the primary analysis sample indicated a statistically significant reduction of distress with an overall pre-post effect size of 1.4 and a reduction in prevalence of severe distress from 61% pretreatment to 14% posttreatment. Among study participants who participated in follow-up (n = 66) 5 months after completing CBT-PD, reduction in distress was maintained.

Summary of findings regarding CBT for adults: There is not enough research that CBT-PD is effective at reducing postdisaster distress for adults based on one study. Hamblen et al. (2009) found statistically significant improvements in study participant distress, but no other studies were identified. CHBRP did not identify any studies that addressed the impact of CBT on SUD or sleep disturbances.

Figure 16. Evidence of Effectiveness of Cognitive Behavioral Therapy for Postdisaster Distress for Adults



Effectiveness of Pharmacotherapy Treatment for People Exposed to Natural Disasters

CHBRP did not identify any literature assessing the effectiveness of pharmacotherapy treatment for children or adults who had been exposed to natural disasters.

Summary of findings regarding pharmacotherapy treatment for people exposed to natural disasters: There is not enough research that pharmacotherapy treatment is effective for people who have been exposed to natural disasters. No studies were identified.

Figure 17. Evidence of Effectiveness of Pharmacotherapy for PTSD, Depression, Anxiety, SUD, and Sleep Disturbances

Summary of Findings

CHBRP identified a large body of literature demonstrating that psychotherapy and pharmacotherapy treatments are effective for people experiencing PTSD, anxiety, depression, SUD, and sleep disturbances as part of general trauma care.

The medical effectiveness review reached the following conclusions for *people experiencing general trauma*:

For *psychotherapy*:

- There is *very strong evidence* that psychotherapy is effective at reducing *PTSD* prevalence and symptoms.
- There is *strong evidence* that psychotherapy is effective at reducing *depression* prevalence and symptoms.
- There is *very strong evidence* that psychotherapy is effective at reducing *anxiety* prevalence and symptoms.
- There is *some evidence* that psychotherapy is effective at reducing *SUD* prevalence and symptoms.
- There is *some evidence* that psychotherapy is effective at reducing *sleep disturbance* prevalence and symptoms.

For *pharmacotherapy*:

- There is *strong evidence* that pharmacotherapy is effective at reducing *PTSD* prevalence and symptoms.
- There is *strong evidence* that pharmacotherapy is effective at reducing *depression* prevalence and symptoms.
- There is *strong evidence* that pharmacotherapy is effective at reducing *anxiety* prevalence and symptoms.
- There is *some evidence* that pharmacotherapy is effective at reducing *SUD* prevalence and symptoms.
- There is *strong evidence* that pharmacotherapy is effective at reducing *sleep disturbance* prevalence and symptoms.

CHBRP identified scant literature specific to the effectiveness of psychotherapy and pharmacotherapy treatments for PTSD, anxiety, depression, SUD, and sleep disturbances among people who have experienced natural disasters. Despite the dearth of literature, CHBRP does not have a reason to believe these therapies, which are effective for treating behavioral health conditions generally, would not also be effective for people seeking treatment due to trauma rooted in experience with a natural disaster. CHBRP considers the following medical effectiveness review conclusions specific to the natural disaster-experiencing population as complementary to the above-described literature and conclusions about general trauma care.

Among *people experiencing a natural disaster*:

- There is *not enough research* that psychosocial treatment is effective at reducing trauma symptoms for children.
- There is *not enough research* that that EMDR treatment is effective at reducing PTSD, anxiety, and depression for children.
- There is *some evidence* that CBT is effective at reducing PTSD diagnoses, PTSD symptoms, depression, and anxiety for children.
- There is *not enough research* that CBT is effective at reducing postdisaster distress for adults.
- There is *not enough research* that pharmacotherapy is effective at reducing PTSD, depression, anxiety, SUD, and sleep disturbances for children or adults.

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Benefit Coverage, Utilization, and Cost Impacts

As discussed in the *Introduction* section, AB 1032 would mandate reimbursement for up to 12 visits per year with a licensed behavioral health provider if an enrollee or insured is in a county where a local or state emergency has been declared due to wildfires. These benefits would apply until 1 year from the date the local or state emergency is lifted, whichever is later.

This section reports the potential incremental impacts of AB 1032 on estimated baseline benefit coverage, utilization, and overall cost.

Analytic Approach and Key Assumptions

As noted in the *Policy Context* section, CHBRP assumed the following:

- Medi-Cal would not be subject to AB 1032's requirements.
- All those eligible for coverage under AB 1032 currently have coverage for behavioral health services regardless of whether or not there is a wildfire. AB 1032 does not expand coverage per se but rather expands access to out-of-network coverage. The enrollee would need to pay for behavioral health visits and then be reimbursed by the insurer, less any cost sharing.
- Enrollees in Health Savings Account (HSA)-qualified high deductible health plans (HDHPs) are included in CHBRP's cost model. CHBRP assumes that enrollees in these plans would be eligible for reimbursement only after meeting their deductible.
- The number of counties and the population impacted by wildfires that are declared states of emergency varies greatly across years. CHBRP used an average population impacted over 5 years of data (2020 to 2024) as the estimate when calculating the number who would be eligible for benefits under AB 1032.
- CHBRP is distinguishing between those who would benefit from the access to behavioral health services afforded by AB 1032 due to the wildfire (wildfire related) and those in the county who are not directly impacted by the wildfire but would benefit from access to behavioral health services due to having unmet need for behavioral health services (unmet need).
- The estimate of the number of people directly impacted by the fire was taken to be the average number of people evacuated in counties with a state emergency declaration between 2020 and 2024.
- The level of unmet need for behavioral health services for individuals not directly impacted by a wildfire but residing in a county with an emergency declaration was estimated using data from the National Survey of Drug Use and Health.
- Because coverage can extend beyond 12 months (time between the date the emergency is declared and 12 months after it ends), CHBRP assumes that some people eligible for coverage will use behavioral health services in a second year. This carryover use is factored into the utilization rates.

How does utilization impact premiums?

Health insurance, by design, distributes risk and expenditures across everyone enrolled in a plan or policy. It does so to help protect each enrollee from the full impact of health care costs that arise from that enrollee's use of prevention, diagnosis, and/or treatment of a covered medical condition, disease, or injury. Changes in utilization among any enrollees in a plan or policy can result in changes to premiums for all enrollees in that plan or policy.

- It is assumed that there is no change in state-regulated insurance coverage resulting from being in a county with a state emergency declaration. While there may be impacts to employment, and thus state-regulated insurance coverage, resulting from wildfires, no data are available to suggest the extent of the changes. CHBRP has not assumed a change in the number of individuals covered by state-regulated insurance coverage as a result of AB 1032.

Baseline and Postmandate Benefit Coverage

As discussed in the *Introduction* section, AB 1032 would apply to state-regulated health insurance, including commercial enrollees and enrollees with insurance through the California Public Employees' Retirement System (CalPERS). Medi-Cal is exempt. It should be noted that DMHC regulates the plans and policies of approximately 74% of enrollees associated with CalPERS, in addition to commercial enrollees. [32]

Table 1 provides estimates of both baseline and postmandate benefit coverage and utilization of behavioral health services for enrollees with state-regulated commercial and CalPERS coverage. There are 22,207,000 people in California who have health insurance potentially subject to state benefit mandates (Table 1).[33] Of these, 13,570,000 have health insurance subject to AB 1032.

Table 1. Impacts of AB 1032 on Benefit Coverage, 2026

	Baseline	Postmandate	Increase/Decrease
Total enrollees with health insurance subject to state benefit mandates (a)	22,207,000	22,207,000	0
Total enrollees with health insurance subject to AB 1032	13,570,000	13,570,000	0
Percentage of enrollees with coverage for mandated benefit	0%	100%	100%
Number of enrollees with fully compliant coverage for mandated benefit	0	13,570,000	13,570,000

Source: California Health Benefits Review Program, 2025.
Notes: (a) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California and CalPERS.[34]
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; DMHC = Department of Managed Health Care.

Baseline and Postmandate Utilization and Unit Cost

The first step in determining the additional cost associated with this proposed legislation was to project the number of people who are reasonably likely to be eligible for this benefit in a given year. This is a difficult and uncertain undertaking (Taylor et al., 2013). The number of wildfires varies by year, as does the number of counties impacted (and the population density of those impacted counties). CHBRP's analysis of data from the California Governor's Office of Emergency Services[35] shows that the number of counties with state emergency declarations due to wildfires and the total population impacted varied greatly from 2020 to 2024 (see Table 2).

[32] For more detail, see CHBRP's resource, *Sources of Health Insurance in California*.
[33] AskCHIS, California Health Interview Survey data for 2023. https://healthpolicy.ucla.edu/our-work/california-health-interview-survey-chis.
[34] For more detail, see CHBRP's resource, *Sources of Health Insurance in California*.
[35] California Governor's Office of Emergency Services. https://www.caloes.ca.gov/office-of-the-director/policy-administration/legal-affairs/emergency-proclamations/.

Table 2. Number of California Counties With State Emergency Declarations Due to Wildfires and Total Population Impacted, 2020–2024

Year	Number of Counties Impacted by State Emergency Declaration Due to Wildfires	Number of Residents in Those Counties
2020	13	11,400,000
2021	6	500,000
2022	8	3,400,000
2023	2	66,000
2024	12	18,900,000

Source: CHBRP analysis of California Governor's Office of Emergency Services data.

The average across the 5 years of data suggests that about 3.6 million people with state-regulated health insurance subject to AB 1032 will reside in counties with a state emergency declaration (Table 3). The estimate is based only on the number of wildfires in counties with a state emergency declaration (not a local emergency declaration) from 2020 to 2024 (not including the 2025 Los Angeles fires). The actual number may vary significantly from year to year based on the number of wildfires and the population of the counties with a state emergency declaration. The 3.6 million estimate is based on the number of counties impacted by state emergency declarations only so likely is an underestimation of the total number of people likely to be impacted. The legislation also covers local emergencies, but CHBRP could not find reliable data on the number of local emergencies declared due to wildfires in a given year.

Table 3. Impacts of AB 1032 on Utilization and Unit Cost, 2026

	Baseline	Postmandate	Increase/Decrease	Percentage Change
Enrollees in counties with an emergency declaration due to wildfires	3,586,000	3,586,000	0	0%
Utilizers of reimbursement for behavioral health	0	16,170	16,170	100%
Wildfire related	0	6,240	6,240	100%
Unmet need	0	9,930	9,930	100%
Total reimbursed behavioral health visits	0	194,050	194,050	100%
Wildfire related	0	74,900	74,900	100%
Unmet need	0	119,150	119,150	100%
Billed cost per visit	N/A	$240.00	$240.00	100%

Source: California Health Benefits Review Program, 2025.

AB 1032 would mandate that all residents in a county would be eligible even if they are not directly impacted by the wildfire. Often, wildfires impact only one part of the county but have limited or no impact on other parts of the county. For the purposes of this analysis, it is useful to distinguish between those individuals who are directly impacted by the wildfire and thus might benefit from having access to behavioral health services because of the wildfire (wildfire related), and those who, although not directly impacted by the wildfire, would still be eligible to access behavioral health services for reasons other than due to the wildfire (unmet need).

Identifying the number of people who will need access to behavioral health services due to the wildfire (wildfire related) requires identifying the number of people directly impacted by a given fire and the rate of psychological distress – and thus need for behavioral health services – for those individuals. As discussed above, previous studies have reported rates of psychological distress of over 50% after wildfires (Jenkins et al., 2009; Lowe et al., 2019; National Center for PTSD, 2025d), including 55% of people impacted by the Maui fires in 2023 (Juarez et al., 2024) and 57% impacted by the Fort McMurray fire in 2016 (Belleville et al., 2021). A study with data from the Victorian Black Saturday bushfires in 2009 reported that 32.7% of respondents in the high-impacted communities reported psychological distress, and it did not distinguish psychological distress due to the wildfires and distress due to other factors (suggesting that not all the reported need was due to the wildfires) (Bryant et al., 2014). The number of people who will need access to behavioral health services because of a wildfire (wildfire related) will therefore likely vary significantly depending on the characteristics of the fire (i.e., amount of smoke, duration, size), and the reported rates of distress are likely to vary according to the characteristics of the fire and the population studied.

CHBRP was unable to find accurate data in California on the number of people directly impacted by a given wildfire. Following the methodology used in a previous study (Binet et al., 2021), CHBRP estimated the number of people impacted by a fire using the number of evacuees due to each fire. While this might tend to underestimate the number of people who have a need for behavioral health services, as some with a need related to the fire may not evacuate, it does provide an indication of the scope of the fire and the number of people likely to be directly impacted. While information on the number of evacuees from fires in California is scant, information from news reports and other published information provides an estimate of the number of evacuees in counties with a state emergency declaration due to a wildfire during the 2020-2024 period (Table 4).

Table 4. Number and Percent of People Expected to Be Evacuated in California Counties, 2020–2024

Year	Number of People Expected to Be Evacuated	Percentage of People Expected to Be Evacuated
2020	132,100	2.3
2021	10,300	5.0
2022	10,500	0.6
2023	2,816	8.9
2024	152,614	1.6

Source: CHBRP analysis.

CHBRP estimates that an average of 32,339 people eligible for coverage under AB 1032 (or 0.9% of the total population of those counties) might be expected to be evacuated each year in counties with a state emergency declaration. Following Binet et al. (2021), it was estimated that 57.5% (18,595) of those evacuated would have symptoms or a probable diagnosis that would benefit from having access to behavioral health services and that 18.9% (6,112) would likely receive behavioral health services regardless of the expanded coverage resulting from AB 1032, meaning that 38.6% (12,483) could benefit from expanded access to out-of-network behavioral health providers. Not all of those in need of access to behavioral health services would access the services postmandate. CHBRP assumes that 50% of these individuals would access services, meaning that the additional number of utilizers postmandate would be 6,240 (Table 3).

As mentioned above, AB 1032 would expand coverage to all individuals who live in the county, regardless of whether they are directly impacted by the wildfires. A survey of carriers in California suggested that all (100%) enrollees with state-regulated insurance would have coverage for behavioral health services regardless of whether there is a wildfire, meaning that AB 1032 would not expand coverage per se. Instead, AB 1032 would expand access to out-of-network coverage.

The number of individuals with unmet need for behavioral health services is derived from the National Survey on Drug Use and Health. The survey suggests that approximately 687,841 people, or 19.4% of the population in counties with a state emergency declaration, would benefit from expanded access to behavioral health services. [36] Analysis of data from the commercially insured California population suggests that only 5.39% currently utilize behavioral health services. This means an estimated 496,438 people, or 14.0% of the population who are in counties with a state emergency declaration but not impacted by wildfires, would have an unmet need for behavioral health services that might be met by AB 1032 reimbursing out-of-network coverage.

The actual number of people with unmet need who might actually access the out-of-network behavioral health services is unknown. CHBRP assumed that 2% of those with an unmet need would access out-of-network services, based on the fact that these individuals already have access to in-network behavioral health services. This means only those facing an inability to access in-network care would benefit from having access to out-of-network care, and they would be required to pay upfront for all services and then get reimbursed. There are significant other barriers to accessing mental health coverage that are not addressed by AB 1032. As shown in Table 3, using this assumption results in an estimate of 9,930 people who would utilize the out-of-network coverage to meet their unmet needs.

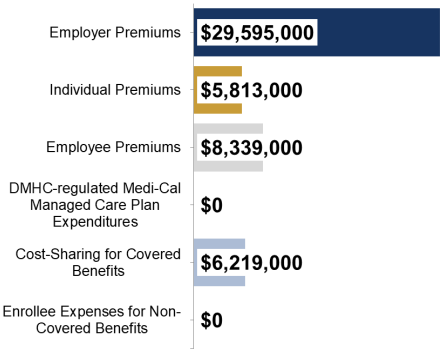
The additional use of behavioral health services that might be expected as a result of the coverage afforded by AB 1032 would be limited to people residing in counties with an emergency declaration due to wildfires who:

- Have a behavioral health need, and
- Would be willing and have the resources available to pay for the services out of pocket and then get reimbursed by their insurance company for the use of out-of-network services (since in-network services would already be covered).

Baseline and Postmandate Expenditures

For DMHC-regulated plans and CDI-regulated policies, AB 1032 would increase total premiums paid by employers and enrollees for newly covered benefits. Enrollee cost sharing would increase. This would result in an increase of total net annual expenditures for enrollees with DMHC-regulated plans and CDI-regulated policies (Figure 17).

Figure 17. Expenditure Impacts of AB 1032



Source: California Health Benefits Review Program, 2025.

Taken together, it is estimated that AB 1032 will, on average, result in an additional 16,170 people accessing behavioral health services in counties with a state emergency declaration due to a wildfire.

AB 1032 states that individuals will have access to 12 visits per year and that access begins when the state of emergency is declared and lasts for 1 year after it ends. To illustrate, suppose that the state of emergency is declared at the beginning of July, or the start of the 3rd quarter of 2026, and that it is formally ended on December 31st, or the end of the 4th quarter of 2026. The coverage would therefore last for 18 months: July 1st, 2026, to December 31st, 2027. Unless the visits were prorated during the 2nd year, individuals would have access to 12 visits between July 1st, 2026, and June 30th, 2027, and then an additional 12 visits for the period of July 1st, 2027 to December 31st, 2027.

[36] National Survey on Drug Use and Health, 2023. https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health

CHBRP estimates that those utilizing the services will have 12 visits in a given year. This represents the maximum number allowed by AB 1032 but is lower than the average number of annual visits per utilizer seen in historical claims data from the commercially insured population in California. As shown in Table 3, CHBRP estimates that this will result in an additional 194,050 visits per year, with 74,900 arising from those directly impacted by the wildfire (wildfire related) and 119,150 from others in the county (unmet need). At an estimated cost of $240 for an out-of-network visit, the total estimated cost due to AB 1032 in a given year would be about $50 million (Table 5). This would represent a change in total expenditures of 0.03%.

Table 5. Impacts of AB 1032 on Expenditures, 2026

	Baseline	Postmandate	Increase/Decrease	Percentage Change
Premiums				
Employer-sponsored (a)	$68,752,638,000	$68,779,524,000	$26,886,000	0.04%
CalPERS employer (b)	$7,881,873,000	$7,884,582,000	$2,709,000	0.03%
Medi-Cal (excludes COHS) (c)	$31,818,731,000	$31,818,731,000	$0	0.00%
Enrollee premiums				
Enrollees, individually purchased insurance	$21,757,790,000	$21,763,603,000	$5,813,000	0.03%
Outside Covered California	$6,011,399,000	$6,013,017,000	$1,618,000	0.03%
Through Covered California	$15,746,391,000	$15,750,586,000	$4,195,000	0.03%
Enrollees, group insurance (d)	$21,712,866,000	$21,721,205,000	$8,339,000	0.04%
Enrollee out-of-pocket expenses				
Cost sharing for covered benefits (deductibles, copays, etc.)	$18,992,422,000	$18,998,641,000	$6,219,000	0.03%
Expenses for noncovered benefits (e) (f)	$0	$0	$0	0.00%
Total expenditures	$170,916,320,000	$170,966,286,000	$49,966,000	0.03%

Source: California Health Benefits Review Program, 2025.
Notes: (a) In some cases, a union or other organization. Excludes CalPERS.
(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 54.0% are state retirees, state employees, or their dependents.
(c) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans. In addition, it seems likely that there would also be a proportional increase of $0 million for Medi-Cal beneficiaries enrolled in COHS managed care.
(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.
(e) Includes only expenses 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.
(f) For covered benefits, such expenses would be eliminated, although enrollees with newly compliant benefit coverage might pay some expenses if benefit coverage is denied (through utilization management review).
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care.

Premiums

At the end of this section, Table 6 and Table 7 present baseline and postmandate expenditures by market segment for DMHC-regulated plans and CDI-regulated policies. The tables present per member per month (PMPM) premiums,

enrollee expenses for both covered and noncovered benefits, and total expenditures (premiums as well as enrollee expenses).

Changes in premiums as a result of AB 1032 would vary by market segment. Note that such changes are related to the number of enrollees (see Table 1, Table 6, and Table 7), with health insurance that would be subject to AB 1032.

Commercial

Premium increases as a result of AB 1032 would total about $43.7 million, or less than 1% of total premiums for all aspects of the Commercial market. Premiums would increase among DMHC-regulated commercial plans, ranging from $0.22 per member per month (PMPM) for individual plans to $0.28 PMPM for large-group plans. Among CDI-regulated policies, premiums would increase from $0.25 PMPM for small-group plans to $0.28 PMPM for individual and large-group plans.

For enrollees whose plans/policies are purchased inside the Covered California marketplace, premiums would increase by $4,195,000.

CalPERS

For enrollees associated with CalPERS in DMHC-regulated plans, premiums could be expected to increase by $2.7 million, or $0.29 PMPM.

Medi-Cal

Medi-Cal is not subject to AB 1032.

Enrollee Expenses

CHBRP projects an increase in utilization of behavioral health visits and therefore an increase in enrollee cost sharing of $6.2 million, or .03%.

It is possible that some enrollees incurred expenses related to services for which coverage was denied, but CHBRP cannot estimate the frequency with which such situations occur and so cannot offer a calculation of impact.

Postmandate Administrative and Other Expenses

CHBRP estimates that the increase in administrative costs of DMHC-regulated plans and/or CDI-regulated policies will remain proportional to the increase in premiums. CHBRP assumes that if health care costs increase as a result of increased utilization or changes in unit costs, there is a corresponding proportional increase in administrative costs. CHBRP assumes that the administrative cost portion of premiums is unchanged. All health plans and insurers include a component for administration and profit in their premiums.

Other Considerations for Policymakers

In addition to the impacts a bill may have on benefit coverage, utilization, and cost, related considerations for policymakers are discussed below.

Impacts on Health and Other Health Care Expenditures

The cost estimates reported in Tables 1, 3, and 5 focus only on the cost of behavioral health services and do not include changes, either additional spending or cost savings, on other types of health care services. While there is evidence that access to behavioral health care services can be beneficial, including for those who have been evacuated from a natural disaster, CHBRP did not find any evidence on the impact on short- and long-term health care costs.

Postmandate Changes in the Number of Uninsured Persons

Because the change in average premiums does not exceed 1% for any market segment (see Table 5, Table 6, and Table 7), CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of AB 1032.

Changes in Public Program Enrollment

CHBRP estimates that the mandate would produce no measurable impact on enrollment in publicly funded insurance programs due to the enactment of AB 1032.

How Lack of Benefit Coverage Results in Cost Shifts to Other Payers

No cost shifting is expected from this legislation.

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Table 6. Baseline Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2026

	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 (Excludes COHS) (c)*		*Large Group*	*Small Group*	*Individual*	
					Under 65	*65+*				
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	8,034,000	2,076,000	2,181,000	914,000	7,787,000	850,000	264,000	65,000	36,000	22,207,000
Total enrollees in plans/policies subject to AB 1032	8,034,000	2,076,000	2,181,000	914,000	0	0	264,000	65,000	36,000	13,570,000
Premiums										
Average portion of premium paid by employer (e)	$557.33	$507.76	$0.00	$718.62	$276.79	$583.72	$609.11	$567.83	$0.00	$108,453,242,000
Average portion of premium paid by enrollee	$145.58	$212.63	$818.51	$139.09	$0.00	$0.00	$224.25	$185.49	$777.47	$43,470,656,000
Total premium	**$702.91**	**$720.39**	**$818.51**	**$857.71**	**$276.79**	**$583.72**	**$833.35**	**$753.32**	**$777.47**	**$151,923,898,000**
Enrollee expenses										
Cost sharing for covered benefits (deductibles, copays, etc.)	$64.42	$164.36	$272.54	$81.59	$0.00	$0.00	$122.99	$249.30	$173.93	$18,992,422,000
Expenses for noncovered benefits (f)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0
Total expenditures	**$767.33**	**$884.75**	**$1,091.05**	**$939.30**	**$276.79**	**$583.72**	**$956.34**	**$1,002.63**	**$951.40**	**$170,916,320,000**

Source: California Health Benefits Review Program, 2025.
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 51.7% 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.[37]
(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; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care.

[37] For more detail, see CHBRP's resource *Sources of Health Insurance in California*.

Table 7. Postmandate Change in Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2026

	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 (Excludes COHS) (c)*		*Large Group*	*Small Group*	*Individual*	
					Under 65	*65+*				
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	8,034,000	2,076,000	2,181,000	914,000	7,787,000	850,000	264,000	65,000	36,000	22,207,000
Total enrollees in plans/policies subject to AB 1032	8,034,000	2,076,000	2,181,000	914,000	0	0	264,000	65,000	36,000	13,570,000
Premiums										
Average portion of premium paid by employer (e)	$0.2237	$0.1818	$0.0000	$0.2470	$0.0000	$0.0000	$0.2030	$0.1869	$0.0000	$29,595,000
Average portion of premium paid by enrollee	$0.0584	$0.0761	$0.2175	$0.0478	$0.0000	$0.0000	$0.0747	$0.0611	$0.2788	$14,152,000
Total premium	$0.2822	$0.2579	$0.2175	$0.2947	$0.0000	$0.0000	$0.2777	$0.2480	$0.2788	**$43,747,000**
Enrollee expenses										
Cost sharing for covered benefits (deductibles, copays, etc.)	$0.0259	$0.0585	$0.0723	$0.0143	$0.0000	$0.0000	$0.0411	$0.0821	$0.0624	$6,219,000
Expenses for noncovered benefits (f)	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0
Total expenditures	$0.3080	$0.3164	$0.2898	$0.3090	$0.0000	$0.0000	$0.3188	$0.3301	$0.3412	**$49,965,000**
Percent change										
Premiums	0.0401%	0.0358%	0.0266%	0.0344%	0.0000%	0.0000%	0.0333%	0.0329%	0.0359%	0.0288%
Total expenditures	0.0401%	0.0358%	0.0266%	0.0329%	0.0000%	0.0000%	0.0333%	0.0329%	0.0359%	0.0292%

Source: California Health Benefits Review Program, 2025.
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 51.7% 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.[38]
(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 Health Maintenance Organizations; CDI = California Department of Insurance; DMHC = Department of Managed Health; COHS = County Operated Health Systems.

[38] For more detail, see CHBRP's resource *Sources of Health Insurance in California*.

Public Health Impacts

As discussed in the *Introduction* section, AB 1032 would mandate reimbursement for up to 12 visits per year with a licensed behavioral health provider if an enrollee or insured is in a county where a local or state emergency has been declared due to wildfires. These benefits would apply until 1 year from the date the local or state emergency is lifted, whichever is later.

The public health impact analysis includes estimated impacts in the short term (within 12 months of implementation) and in the long term (beyond the first 12 months postmandate). This section estimates the short-term impact[39] of AB 1032 on trauma, PTSD diagnoses and symptoms, depression, anxiety, and postdisaster distress due to wildfires or other natural disasters. See the *Long-Term Impacts* section for discussion of premature death, economic loss, social determinants of health, and other impacts.

Estimated Public Health Outcomes

As presented in the *Background* section, wildfires or other natural disasters result in increased prevalence of behavioral health conditions such as PTSD, depression, anxiety, sleep disorders, and substance use disorders. Following wildfires, research shows increased psychotropic medication use, specifically for antidepressants, antianxiety medications, and mood-stabilizing medications. Emergency department visits for anxiety and schizophrenia rise.

The *Medical Effectiveness* section analyzed available research on the impact of pharmacotherapies and psychotherapies (specifically, cognitive behavioral therapy (CBT) and eye movement desensitization and reprocessing treatment (EMDR)) for treating PTSD, anxiety, depression, SUD, and sleep disturbances as part of general trauma care and among people who experienced natural disasters. CHBRP did not identify research on the impact of behavioral health care on health outcomes for people who have experienced wildfires specifically, but considers the medical effectiveness review conclusions specific to the natural disaster-experiencing population as complementary to the literature and conclusions about general trauma care.

Generally, there is a large body of literature demonstrating that psychotherapy and pharmacotherapy treatments are effective at reducing the prevalence and symptoms of behavioral health conditions common among people exposed to natural disasters. As presented in the *Medical Effectiveness* section, there is *very strong evidence* that psychotherapy is effective at treating PTSD and anxiety. There is *strong evidence* that psychotherapy is effective at treating depression. There is *some evidence* that psychotherapy is effective at treating SUD and sleep disturbances. There is *strong evidence* that pharmacotherapy is effective at treating PTSD, depression, anxiety, and sleep disturbances. This is *some evidence* that pharmacotherapy is effective at treating SUD.

In terms of the impact of visits with behavioral health professionals among people whose behavioral health conditions were rooted in experience with a natural disaster, there is not enough research that psychosocial treatment is effective at reducing trauma symptoms for children or that EMDR treatment is effective at reducing PTSD, anxiety, and depression for children. There is some evidence that CBT is effective at reducing PTSD diagnoses and symptoms, depression, and anxiety for children. There is not enough research that CBT is effective at reducing postdisaster distress for adults.

As presented in the *Benefit Coverage, Utilization, and Cost Impacts* section, the impact of AB 1032 would most likely be concentrated among those residing in counties with an emergency declaration due to wildfires who:

- Have a behavioral health need, and

[39] CHBRP defines short-term impacts as changes occurring within 12 months of bill implementation.

- Would be willing and have the resources available to pay for the services out of pocket and then get reimbursed by their insurance company for the use of out-of-network services (since in-network services would already be covered).

CHBRP also estimates that some people who do not currently use behavioral health services despite having an unmet need for such care would utilize services as a result of expanded access under AB 1032. Overall, there would be an increase in need for behavioral health services, which would increase use (as measured by the number of behavioral health visits). It is important to note that the public health impact would depend on a variety of unknowns, including which counties are affected, the socio-economic status of residents in those counties, the share of the population with unmet need, and the availability of the behavioral health workforce, among others.

In the first year postmandate, among the 13,570,000 people with health insurance subject to AB 1032, an estimated 3,586,000 enrollees would be eligible for expanded access to behavioral health services due to residing in counties with an emergency declaration due to wildfires. An estimated 16,170 people would increase behavioral health services use due to AB 1032; of these, 6,240 people would be directly impacted from the wildfires, and 9,930 would have existing unmet needs.

In the first year postmandate, there would be improved behavioral health outcomes among the population of people who reside in a county with a local or state emergency declaration due to wildfires, have a behavioral health need, have the ability to pay out of pocket for out-of-network care, and who ultimately utilize care and have the cost of behavioral health visits reimbursed. The positive public health outcomes are supported by strong evidence that psychotherapy and pharmacotherapy are medically effective treatments for PTSD, anxiety, and depression; strong evidence that pharmacotherapy is effective at treating sleep disturbances; and some evidence that psychotherapy and pharmacotherapy are effective at treating SUD.

Potential Harms From AB 1032

When data are available, CHBRP estimates the marginal change in relevant harms associated with interventions affected by the proposed mandate. In the case of AB 1032, CHBRP did not identify any evidence of harms from psychotherapy or psychopharmacology on health outcomes.

Impact on Disparities[40]

CHBRP has insufficient information to estimate the impact of AB 1032 on disparities by group within the first 12 months postmandate. However, to the extent that AB 1032 would increase access among higher-income people and families who could afford to pay out of pocket before receiving reimbursement, there could be disparate impacts; in such cases, lower-income families might not be able to pay for care upfront before being reimbursed by their plan or policy. Behavioral health care is estimated to cost an average of $240 per visit (see *Benefit Coverage, Utilization, and Cost Impact* section), and data show that nearly one in three (30.7%) Americans have $500 or less available in their checking and savings accounts for expenses (CFPB, 2023).

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[40] For details about CHBRP's methodological approach to analyzing disparities, see the *Benefit Mandate Structure and Unequal Racial/Ethnic Health Impacts* document.

Long-Term Impacts

In this section, CHBRP estimates the long-term impact of AB 1032, which CHBRP defines as impacts occurring beyond the first 12 months after implementation. These estimates are qualitative and based on the existing evidence available in the literature. CHBRP does not provide quantitative estimates of long-term impacts because of unknown improvements in clinical care, changes in prices, implementation of other complementary or conflicting policies, and other unexpected factors.

A state emergency declaration due to a wildfire often lasts longer than the initial first few months past the date of the disaster event, as shown by the data on recent state emergency declarations. Coverage under AB 1032 would last 1 year following the end of the emergency period, but wildfire impacts can last longer.

Long-Term Utilization and Cost Impacts

Utilization Impacts

To the extent that emergency declarations in counties impacted by wildfires continue, utilization of behavioral health services could increase past the first year postmandate. Since there may be a time lag between when a wildfire event occurs and people's need for behavioral health services, utilization postmandate may extend past 1 year. Additionally, severity of conditions may change over time. As need continues, and to the extent that plans and policies are required to provide coverage under AB 1032, utilization could increase marginally.

Cost Impacts

Should utilization of behavioral health visits increase, premiums and enrollee cost sharing would increase proportionately.

Long-Term Public Health Impacts

There could be longer-term public health impacts of behavioral health services utilization as provided under AB 1032. For instance, since trauma-induced anxiety and depression tend to persist longer past a disaster event, increased access to and use of care may lead to improved outcomes in the long term. Outcomes for PTSD may also improve in the long term to the extent that affected populations receive timely and consistent treatment. In addition, it may take weeks or months for the health benefits of psychotherapy and pharmacotherapy to be fully realized (APA, 2017a; National Center for PTSD, 2025b).

Impacts on Disparities and the Social Drivers of Health[41]

Although gender and age disparities exist and likely contribute to the prevalence of behavioral health conditions including PTSD, anxiety, and depression, CHBRP projects no changes in these that would be attributable to AB 1032. However, there may be changes in behavioral health outcomes by income, since people who are able to afford to pay the copayments and upfront cost of care before applying for reimbursement would be more likely to use services under AB 1032. Additionally, there may be long-term disparities by region, since those residing in areas with local and state emergency declarations due to wildfires may be at increased risk for behavioral health conditions. As shown in the *Background* section, certain California counties are at higher risk of hazard from wildfire than others.

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[41] For more information about SDOH, see CHBRP's Public Health Impact Analysis and Research Approach.

Appendix A. Text of Bill Analyzed

On February 19, 2025, the California Assembly Committee on Health requested that CHBRP analyze AB 1032, as introduced on February 20, 2025.

CALIFORNIA LEGISLATURE— 2025–2026 REGULAR SESSION

ASSEMBLY BILL
NO. 1032

Introduced by Assembly Members Harabedian and Rivas

February 20, 2025

An act to add Section 1374.726 to the Health and Safety Code, and to add Section 10144.45 to the Insurance Code, relating to health care coverage, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 1032, as introduced, Harabedian. Coverage for behavioral health visits.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of mental health and substance use disorders, as defined, under the same terms and conditions applied to other medical conditions.

This bill would generally require an individual or group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, to reimburse an eligible enrollee or insured for up to 12 visits per year with a licensed behavioral health provider if the enrollee or insured is in a county where a local or state emergency has been declared due to wildfires. Under the bill, an enrollee or insured would be entitled to those benefits until one year from the date the local or state emergency is lifted, whichever is later. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

This bill would declare that it is to take effect immediately as an urgency statute.

DIGEST KEY

Vote: 2/3 Appropriation: NO Fiscal Committee: YES Local Program: YES

BILL TEXT

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1374.726 is added to the Health and Safety Code, to read:

1374.726. (a) (1) An individual or group health care service plan contract issued, amended, or renewed on or after January 1, 2026, shall reimburse an eligible enrollee for up to 12 visits per year with a licensed behavioral health provider if the enrollee is in a county where a local or state emergency has been declared due to wildfires.

(2) An enrollee is entitled to the benefits specified in paragraph (1) until one year from the date the local or state emergency is lifted, whichever is later.

(3) For a health care service plan contract that meets the definition of a "high deductible health plan" set forth in Section 223(c)(2) of Title 26 of the United States Code, paragraph (1) shall only apply once an enrollee's deductible has been satisfied for the year.

(b) (1) This section applies to a health care service plan subject to Section 1349.2.

(2) This section does not apply to a specialized health care service plan contract that covers only dental or vision benefits or to coverage under a health care service plan contract for the federal Medicare Program pursuant to Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395 et seq.).

(c) This section does not excuse a health care service plan from complying with Section 1374.72 or any other requirement of this chapter.

(d) For purposes of this section, "licensed behavioral health provider" means a provider licensed under Division 2 (commencing with Section 500) of the Business and Professions Code authorized to render behavioral health services.

SEC. 2. Section 10144.45 is added to the Insurance Code, to read:

10144.45. (a) (1) An individual or group health insurance policy issued, amended, or renewed on or after January 1, 2026, shall reimburse an eligible insured for up to 12 visits per year with a licensed behavioral health provider if the insured is in a county where a local or state emergency has been declared due to wildfires.

(2) An insured is entitled to the benefits specified in paragraph (1) until one year from the date the local or state emergency is lifted, whichever is later.

(3) For a health insurance policy that meets the definition of a "high deductible health plan" set forth in Section 223(c)(2) of Title 26 of the United States Code, paragraph (1) shall only apply once an insured's deductible has been satisfied for the year.

(b) (1) This section applies to an insurer subject to subdivision (i) of Section 740.

(2) This section does not apply to a specialized health insurance policy that covers only dental or vision benefits or to coverage under a health care service plan contract for the federal Medicare Program pursuant to Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395 et seq.).

(c) This section does not excuse a health care service plan from complying with Section 10144.5 or any other requirement of this chapter.

(d) For purposes of this section, "licensed behavioral health provider" means a provider licensed under Division 2 (commencing with Section 500) of the Business and Professions Code authorized to render behavioral health services.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

SEC. 4. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the California Constitution and shall go into immediate effect. The facts constituting the necessity are:

Because the destruction and loss of one's home, belongings, and surrounding community, and the threat to personal safety and the safety of loved ones, can have significant consequences on survivors' behavioral health, which persist for years after, it is necessary for this act to take effect immediately.

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Appendix B. Cost Impact Analysis: Data Sources, Caveats, and Assumptions

With the assistance of CHBRP's contracted actuarial firm, Milliman, Inc., the cost analysis presented in this report was prepared by the faculty and researchers connected to CHBRP's Task Force with expertise in health economics.[42] Information on the generally used data sources and estimation methods, as well as caveats and assumptions generally applicable to CHBRP's cost impacts analyses, are available on CHBRP's website.[43]

This appendix describes analysis-specific data sources, estimation methods, caveats, and assumptions used in preparing this cost impact analysis.

Analysis-Specific Data Sources

Health Cost Guidelines

The health cost guidelines (HCGs) are a health care pricing tool used by actuaries in many of the major health plans in the United States. The guidelines provide a flexible but consistent basis for estimating health care costs for a wide variety of commercial health insurance plans. It is likely that these organizations use the HCGs, among other tools, to determine the initial premium impact of any new mandate. Thus, in addition to producing accurate estimates of the costs of a mandate, we believe the HCG-based values are also good estimates of the premium impact as estimated by the HMOs and insurance companies.

The highlights of the commercial HCGs include:

- Specific major medical, managed care, and prescription drug rating sections and guidance with step-by-step rating instructions.
- Other helpful analysis resources, such as inpatient length of stay distribution tables, Medicare Severity-Adjusted Diagnosis Related Group (MS-DRG) models, and supplementary sections addressing EHBs and mandated benefits, experience rating, and individual and small-group rating considerations.
- Presentation of loosely and well-managed nationwide utilization and cost information by Milliman benefit-aligned service categories used throughout the Rating Structures – inpatient hospital services for both loosely and well-managed are also supported by DRG level utilization and cost benchmarks.
- Annual updates address emerging regulatory considerations such as health care reform and mental health parity requirements.
- Annually updated benefit descriptions used in the HCG service categories.
- Annually updated medical trend assumptions and considerations.
- Presentation of two sets of nationwide area factors to facilitate development of area-specific claim costs, including separate utilization and charge level factors by type of benefit, state and Metropolitan Statistical Area for first-dollar coverage, and composite factors by deductible amount.

[42] CHBRP's authorizing statute requires that CHBRP use a certified actuary or "other person with relevant knowledge and expertise" to determine financial impact.
[43] See CHBRP's Cost Impact Analysis landing page; in particular, see *Cost Impact Analyses: Data Sources, Caveats, and Assumptions*.

- Claim Probability Distributions (CPDs) by type of coverage that contain distributions of claim severity patterns for unique combinations of benefits and member types (adult, child, composite member).
- The Prescription Drug Rating Model (RXRM), an automated rating tool that provides a detailed analysis of prescription drug costs and benefits.
- Impacts of cost sharing levels on utilization by type of service.

Consolidated Health Cost Guidelines Sources Database

Milliman maintains benchmarking and analytic databases that include health care claims data for nearly 60 million commercial lives and over 3 million lives of Medicaid managed care data. This dataset is routinely used to evaluate program impacts on cost and other outcomes.

Detailed Cost Notes Regarding Analysis-Specific Caveats and Assumptions

The analytic approach and key assumptions are determined by the subject matter and language of the bill being analyzed by CHBRP. As a result, analytic approaches may differ between topically similar analyses, and therefore the approach and findings may not be directly comparable. The analysis of AB 1032 was developed using the cost and utilization of professional behavioral health services.

Methodology and Assumptions for Baseline Benefit Coverage

- The population subject to the mandated offering includes individuals covered by DMHC-regulated commercial insurance plans, CDI-regulated policies, and CalPERS plans subject to the requirements of the Knox-Keene Health Care Service Plan Act.
- Behavioral health services are considered an essential health benefit (EHB) in California. However, there is currently no requirement that plans reimburse behavioral health services for out-of-network providers. Therefore, we assumed no coverage for the proposed benefit at baseline.

Methodology and Assumptions for Baseline Utilization, Cost, and Cost Sharing

- Baseline utilization, cost, and cost sharing is assumed to be zero as there is currently no established requirement of reimbursement of out-of-pocket costs for behavioral health services for members living in a county with a wildfire-related public emergency declaration.

Methodology and Assumptions for Postmandate Utilization

- CHBRP calculated the historical average proportion of Californians who live in a county with a fire-related public emergency declaration or who live in a county that experienced a fire-related public emergency declaration which has ended in the previous 12 months. This is subject to potential dramatic year-to-year variation depending on the location and size of wildfires in the future as well as the duration of emergency declarations. For purposes of modeling, this was assumed to be 26.4% of Californians.
- CHBRP estimated the proportion of commercially insured enrollees who receive behavioral health services as well as the average number of visits per utilizer in California in 2023 using data from the Consolidated Health Cost Guidelines Sources Database (CHSD). These values were summarized for members in an HMO and PPO plan separately, and for members seeking services from in network and out of network providers separately.

- CHBRP assumed that the number of utilizers of professional behavioral health services would increase by 8.37% to reflect the increased demand due to the availability of reimbursement through AB 1032. This reflects two components: 39% of this increase (3.23%) was attributed directly to behavioral health needs related to wildfires while the remainder (5.14%) reflects potential pent-up demand for behavioral health services that would be sought as a result of new access to out-of-network providers due to AB 1032 provisions.
- CHBRP assumed that each of the new utilizers of behavioral health services would utilize 12 visits, as allowed by AB 1032. This is lower than average annual visits per utilizer in CHSD.
- CHBRP assumed that all utilization increases due to AB 1032 provisions will occur out of network.

Methodology and Assumptions for Postmandate Cost

- CHBRP relied on CHSD data to estimate the typical billed cost for behavioral health services for members visiting out of network providers, trended to 2026 using a 4.50% annual cost trend.

Methodology and Assumptions for Postmandate Cost Sharing

- CHBRP assumed cost sharing in the postmandate period consistent with cost sharing in historical data by market.

Determining Public Demand for the Proposed Mandate

CHBRP reviews public demand for benefits by comparing the benefits provided by self-insured health plans or policies (which are not regulated by the DMHC or CDI and therefore not subject to state-level mandates) with the benefits that are provided by plans or policies that would be subject to the mandate.

Among publicly funded self-insured health insurance policies, the preferred provider organization (PPO) plans offered by CalPERS have the largest number of enrollees. The CalPERS PPOs currently provide benefit coverage similar to what is available through group health insurance plans and policies that would be subject to the mandate.

To further investigate public demand, CHBRP used the bill-specific coverage survey to ask plans and insurers who act as third-party administrators for (non-CalPERS) self-insured group health insurance programs whether the relevant benefit coverage differed from what is offered in group market plans or policies that would be subject to the mandate. The responses indicated that there were no substantive differences.

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References

Adu M, Agyapong B, Agyapong V. Children's psychological reactions to wildfires: a review of recent literature. *Current Psychiatry Reports*. 2023;25(11):603-616. doi:10.1007/s11920-023-01451-7

Agyapong VIO, Hrabok M, Juhas M, et al. Prevalence rates and predictors of generalized anxiety disorder symptoms in residents of Fort McMurray six months after a wildfire. *Frontiers in Psychiatry.* 2018;9:345. https://doi.org/10.3389/fpsyt.2018.00345

American Psychological Association (APA). About Prescribing Psychologists. 2022. https://www.apaservices.org/advocacy/issues/prescriptive-authority/prescribing-psychologists. Accessed April 14, 2025.

American Psychological Association (APA). How Long Will It Take for Treatment to Work? 2017a. Available at: https://www.apa.org/ptsd-guideline/patients-and-families/length-treatment. Accessed April 14, 2025.

American Psychological Association (APA). Insurance Challenges Limit Psychologists' Capacity to Address Ongoing Mental Health Needs. Updated January 8, 2025. Available at: https://www.apa.org/news/press/releases/2024/12/insurance-challenges-limit-psychologists. Accessed March 24, 2025.

American Psychological Association (APA). What Is Cognitive Behavioral Therapy? 2017b. Available at: https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral?. Accessed March 24, 2025.

American Psychological Association (APA). What Is EMDR Therapy and Why Is It Used to Treat PTSD? December 21, 2023. Available at: https://www.apa.org/topics/psychotherapy/emdr-therapy-ptsd. Accessed March 24, 2025.

American Society of Addiction Medicine (ASAM). Definition of Addiction. September 15, 2019. Available at: https://www.asam.org/quality-care/definition-of-addiction. Accessed March 25, 2025.

Bandelow B, Reitt M, Röver C, Michaelis S, Görlich Y, Wedekind D. Efficacy of treatments for anxiety disorders: a meta-analysis. *International Clinical Psychopharmacology*. 2015;30(4):183-192. doi:10.1097/YIC.0000000000000078

Belleville G, Ouellet MC, Lebel J, et al. Psychological symptoms among evacuees from the 2016 Fort McMurray wildfires: a population-based survey one year later. *Frontiers in Public Health*. 2021;9:655357.

Berberian AG, Gonzalez DJX, Cushing LJ. Racial disparities in climate change-related health effects in the United States. *Current Environment Health Reports.* 2022;9(3):451-464. https://doi.org/10.1007/s40572-022-00360-w

Binet É, Ouellet MC, Lebel J, et al. A portrait of mental health services utilization and perceived barriers to care in men and women evacuated during the 2016 Fort McMurray wildfires. *Administration and Policy in Mental Health*. 2021;48(6):1006-1018. doi:10.1007/s10488-021-01114-w

Bradley R, Greene J, Russ E, Dutra L, Westen D. A multidimensional meta-analysis of psychotherapy for PTSD. *American Journal of Psychiatry*. 2005;162(2):214-227. doi:10.1176/appi.ajp.162.2.214

Brown MRG, Agyapong V, Greenshaw AJ, et al. Significant PTSD and other mental health effects present 18 months after the Fort McMurray wildfire: findings from 3,070 grades 7-12 students. *Frontiers in Psychiatry*. 2019;10:623. doi:10.3389/fpsyt.2019.00623

Bryant RA, Waters E, Gibbs L, et al. Psychological outcomes following the Victorian Black Saturday bushfires. *Australian and New Zealand Journal of Psychiatry*. 2014;48(7):634-643. doi:10.1177/0004867414534476

Buechi H, Cameron D, Heard S, Plantinga AJ, Weber P. Long-Term Trends in Wildfire Damages in California. Environmental Market Solutions Lab, University of California, Santa Barbara. 2019. Available at: https://emlab.ucsb.edu/sites/default/files/documents/wildfire-brief.pdf. Accessed March 25, 2025.

Burman A, Haeder SF, Xu WY. Provider directory inaccuracy and timely access for mental health care. *American Journal of Managed Care.* 2023;29(2):96-102. https://doi.org/10.37765/ajmc.2023.89318

Buscemi N, Vandermeer B, Friesen C, et al. The efficacy and safety of drug treatments for chronic insomnia in adults: a meta-analysis of RCTs. *Journal of General Internal Medicine*. 2007;22(9):1335-1350. doi:10.1007/s11606-007-0251-z

California Department of Forestry and Fire Protection. Statistics. Last reviewed 2025. Available at: https://www.fire.ca.gov/our-impact/statistics. Accessed March 24, 2025.

California Health Care Foundation (CHCF). Mental Health in California: Waiting for Care. July 2022a. https://www.chcf.org/publication/mental-health-california-almanac/. Last accessed April 4, 2025.

California Health Care Foundation (CHCF). Substance Use in California: Prevalence and Treatment. January 2022b. https://www.chcf.org/publication/substance-use-in-california-almanac/. Last accessed April 4, 2025.

California Health Information Survey (CHIS). Delayed Or Forgone Mental Health Care. 2023. Available at: http://ask.chis.ucla.edu. Accessed March 26, 2025.

Chemtob CM, Nakashima J, Carlson JG. Brief treatment for elementary school children with disaster-related posttraumatic stress disorder: a field study. *Journal of Clinical Psychology*. 2002a;58(1):99-112. doi:10.1002/jclp.1131

Chemtob CM, Nakashima JP, Hamada RS. Psychosocial intervention for postdisaster trauma symptoms in elementary school children: a controlled community field study. *Archives of Pediatric & Adolescent Medicine*. 2002b;156(3):211-216. doi:10.1001/archpedi.156.3.211

Chen AI, Ebisu K, Benmarhnia T, Basu R. Emergency department visits associated with wildfire smoke events in California, 2016-2019. *Environmental Research*. 2023;238(Pt 1):117154. doi:10.1016/j.envres.2023

Christopher B. New Fire Maps Put Nearly 4 Million Californians in Hazardous Zones. What Does That Mean for the People Who Live There? CalMatters. March 24, 2025. Available at: https://calmatters.org/housing/2025/03/calfire-maps-hazard-california/. Accessed March 25, 2025.

Cipriani A, Furukawa TA, Salanti G, et al. Comparative efficacy and acceptability of 21 antidepressant drugs for the acute treatment of adults with major depressive disorder: a systematic review and network meta-analysis. *Lancet*. 2018;391(10128):1357-1366. doi:10.1016/S0140-6736(17)32802-7

Consumer Financial Protection Bureau (CFPB), Office of Research. Making Ends Meet in 2023: Insights From the Making Ends Meet Survey. December 1, 2023. Available at: https://www.consumerfinance.gov/data-research/research-reports/making-ends-meet-in-2023-insights-from-the-making-ends-meet-survey/. Last accessed April 14, 2025.

Corley SS, Ornstein KA, Rasul R, et al. Mental Health Effects of Hurricane Sandy on older adults. *Journal of Applied Gerontology*. 2022;41(4):1131-1142. https://doi.org/10.1177/07334648211052992

Dennis M, Scott CK. Managing addiction as a chronic condition. *Addiction Science & Clinical Practice*. 2007;4(1):45-55. doi:10.1151/ascp07414

Department of Managed Health Care (DMHC). DMHC, Kaiser Permanente Reach Settlement Agreement to Transform Plan's Behavioral Health Care Delivery System and Improve Behavioral Health Statewide. October 12, 2023. Available at: https://www.dmhc.ca.gov/Resources/Newsroom/PressReleases/October12,2023.aspx. Accessed April 14, 2025.

D'Evelyn SM, Nerenberg I, Blancas M, et al. Stressors for farmworker parents during wildfire season. *BMC Public Health*. 2024;24(1):3314. https://doi.org/10.1186/s12889-024-20671-x

Federal Emergency Management Agency (FEMA). National Risk Index. 2025. Available at: https://hazards.fema.gov/nri/. Accessed April 4, 2025.

Fergusson DM, Horwood LJ, Boden JM, Mulder RT. Impact of a major disaster on the mental health of a well-studied cohort. *JAMA Psychiatry*. 2014;71(9):1025-1031. https://doi.org/10.1001/jamapsychiatry.2014.652

Garfin DR, Thompson RR, Holman EA, Wong-Parodi G, Silver RC. Association between repeated exposure to hurricanes and mental health in a representative sample of Florida residents. *JAMA Network Open*. 2022;5(6):e2217251. https://doi.org/10.1001/jamanetworkopen.2022.17251

Goldman EE, Bauer D, Newman DL, et al. A school-based post-Katrina therapeutic intervention. *Administration and Policy in Mental Health*. 2015;42(3):363-372. doi:10.1007/s10488-014-0576-

Goodwin LR Jr, Sias SM. Severe substance use disorder viewed as a chronic condition and disability. Journal of Rehabilitation. 2014;80(4):42-49.

Hamblen JL, Norris FH, Pietruszkiewicz S, Gibson LE, Naturale A, Louis C. Cognitive behavioral therapy for postdisaster distress: a community based treatment program for survivors of Hurricane Katrina. *Administration and Policy in Mental Health*. 2009;36(3):206-214. doi:10.1007/s10488-009-0213-

Harada N, Shigemura J, Tanichi M, et al. Mental health and psychological impacts from the 2011 Great East Japan Earthquake Disaster: a systematic literature review. *Disaster and Military Medicine*. 2015;1:17. https://doi.org/10.1186/s40696-015-0008-x

Heanoy EZ, Brown NR. Impact of natural disasters on mental health: evidence and implications. *Healthcare (Basel)*. 2024;12(18):1812. doi:10.3390/healthcare12181812

Heid AR, Pruchno R, Cartwright FP, Wilson-Genderson M. Exposure to Hurricane Sandy, neighborhood collective efficacy, and post-traumatic stress symptoms in older adults. *Aging & Mental Health.* 2016;21(7):742-750. https://doi.org/10.1080/13607863.2016.1154016

Hoskins M, Pearce J, Bethell A, et al. Pharmacotherapy for post-traumatic stress disorder: systematic review and meta-analysis. *Br J Psychiatry*. 2015;206(2):93-100. doi:10.1192/bjp.bp.114.148551

Howard C, Rose C, Dodd W, et al. SOS! Summer of Smoke: a retrospective cohort study examining the cardiorespiratory impacts of a severe and prolonged wildfire season in Canada's high subarctic. *BMJ Open.* 2021;11:e037029. doi:10.1136/bmjopen-2020-037029

Hrabok M, Delorme A, Agyapong VIO. Threats to mental health and well-being associated with climate change. *Journal of Anxiety Disorders*. 2020;76:102295. https://doi.org/10.1016/j.janxdis.2020.102295

Jaycox LH, Cohen JA, Mannarino AP, et al. Children's mental health care following Hurricane Katrina: a field trial of trauma-focused psychotherapies. *Journal of Traumatic Stress*. 2010;23(2):223-231. doi:10.1002/jts.20518

Jenkins JL, Hsu EB, Sauer LM, Hsieh YH, Kirsch TD. Prevalence of unmet health care needs and description of health care–seeking behavior among displaced people after the 2007 California wildfires. Disaster Medicine and Public Health Preparedness. 2009;3(2 suppl):S24-S28. doi:10.1097/DMP.0b013e31819f1afc

Juarez R, Maunakea A, Bonham C, Bond-Smith D, Wada C. Maui Wildfire Exposure Study: Community Health, Wellbeing, and Resilience. May 15, 2024. University of Hawaii Economic Research Organization. Accessed March 24, 2025. Available at: https://uhero.hawaii.edu/wp-content/uploads/2024/05/MauiExposureStudy.pdf. Accessed March 24, 2025.

Kushel M, Moore T, Birkmeyer J, et al. Toward a New Understanding: The California Statewide Study of People Experiencing Homelessness. UCSF Benioff Homelessness and Housing Initiative; 2023. Available at: https://homelessness.ucsf.edu/sites/default/files/2023-06/CASPEH_Report_62023.pdf. Accessed April 7, 2025.

Lai BS, La Greca AM, Brincks A, Colgan CA, D'Amico MP, Lowe S, Kelley ML. Trajectories of posttraumatic stress in youths after natural disasters. *JAMA Network Open*. 2021;4(2):e2036682. doi:10.1001/jamanetworkopen.2020.36682

Legislative Analyst's Office (LAO). Frequently Asked Questions About Wildfires in California. 2025. Available at: https://lao.ca.gov/Publications/Report/4952#How_does_wildfire_risk_vary_across_the_state.3F. Accessed April 13, 2025.

Le Roux IH, Cobham VE. Psychological interventions for children experiencing PTSD After exposure to a natural disaster: a scoping review. *Clinical Child and Family Psychology Review*. 2021;25(2):249-282. doi:10.1007/s10567-021-00373-1

Lewis C, Roberts NP, Andrew M, Starling E, Bisson JI. Psychological therapies for post-traumatic stress disorder in adults: systematic review and meta-analysis. *European Journal of Psychotraumatology*. 2020;11(1):1729633. doi:10.1080/20008198.2020.1729633

Lowe SR, Bonumwezi JL, Valdespino-Hayden Z, Galea S. Posttraumatic stress and depression in the aftermath of environmental disasters: a review of quantitative studies published in 2018. *Current Environmental Health Reports*. 2019;6:344-360. https://doi.org/10.1007/s40572-019-00245-5

Magill M, Ray LA. Cognitive-behavioral treatment with adult alcohol and illicit drug users: a meta-analysis of randomized controlled trials. *Journal of Studies on Alcohol and Drugs*. 2009;70(4):516-527. doi:10.15288/jsad.2009.70.516

Mateu-Mollá J, Pérez-Gálvez B, Villanueva-Blasco VJ. Pharmacological treatment for substance use disorder: a systematic review. *Addictive Behaviors*. 2025;163:108242. doi:10.1016/j.addbeh.2024.108242

National Center for PTSD. Disaster Event Resources: For Everyone. 2025a. Updated March 26, 2025. Available at: https://www.ptsd.va.gov/disaster_events/for_everyone/index.asp. Accessed April 13, 2025.

National Center for PTSD. Medications for PTSD. 2025b. Updated March 26, 2025. Available at: https://www.ptsd.va.gov/understand_tx/meds_for_ptsd.asp. Accessed April 14, 2025.

National Center for PTSD. PTSD and DSM-5. 2025c. Updated March 25, 2025. Available at: https://www.ptsd.va.gov/professional/treat/essentials/dsm5_ptsd.asp. Accessed April 12, 2025.

National Center for PTSD. 2025d. Updated March 26, 2025. The Impact of Disaster Events on Mental Health. 2025. Available at: https://www.ptsd.va.gov/disaster_events/for_providers/mental_health_impact.asp. Accessed April 7, 2025.

National Child Traumatic Stress Network (NCTSN). Age-Related Reactions to a Traumatic Event. 2010. Available at: https://www.nctsn.org/resources/age-related-reactions-traumatic-event. Accessed March 25, 2025.

National Institute on Drug Abuse (NIDA). Magnitude. Drug Abuse and Addiction: One of America's Most Challenging Public Health Problems. 2023. Available at: https://archives.nida.nih.gov/publications/drug-abuse-addiction-one-americas-most-challenging-public-health-problems/addiction-chronic-disease. Accessed March 2025.

Norris F, Friedman MJ, Watson PJ, Byrne CM, Diaz E, Kaniasty K. 60,000 disaster victims speak: part I. An empirical review of the empirical literature, 1981–2001. *Psychiatry.* 2002;65(3):207-239. doi:10.1521/psyc.65.3.207.20173

North CS, Pfefferbaum B. Mental health response to community disasters: a systematic review. *JAMA*. 2013;310(5):507-518. https://doi.org/10.1001/jama.2013.107799

Norton PJ, Price EC. A meta-analytic review of adult cognitive-behavioral treatment outcome across the anxiety disorders. *Journal of Nervous and Mental Disease*. 2007;195(6):521-531. doi:10.1097/01.nmd.0000253843.70149.9a

Panchal N, Lo J. Exploring the Rise in Mental Health Care Use by Demographics and Insurance Status. August 1, 2024. Available at: https://www.kff.org/mental-health/issue-brief/exploring-the-rise-in-mental-health-care-use-by-demographics-and-insurance-status/. Accessed April 14, 2025.

Pietrzak RH, Southwick SM, Tracy M, Galea S, Norris FH. Posttraumatic stress disorder, depression, and perceived needs for psychological care in older persons affected by Hurricane Ike. *Journal of Affective Disorders*. 2012a;138(1-2):96-103. doi:10.1016/j.jad.2011.12.018

Pietrzak RH, Tracy M, Galea S, Kilpatrick DG, Ruggiero KJ, Hamblen JL, Southwick SM, Norris FH. Resilience in the face of disaster: prevalence and longitudinal course of mental disorders following Hurricane Ike. *PLoS One*. 2012b;7(6):e38964. https://doi.org/10.1371/journal.pone.0038964

Rivera-González AC, Purtle J, Kaholokula JK, Stimpson JP, Ortega AN. Maui wildfire and 988 Suicide and Crisis Lifeline call volume and capacity. *JAMA Network Open*. 2024;7(11):e2446523. https://doi.org/10.1001/jamanetworkopen.2024.46523

Saitz R, Larson MJ, LaBelle C, Richardson J, Samet JH. The case for chronic disease management for addiction. *Journal of Addiction Medicine*. 2008;2(2):55-65. doi:10.1097/ADM.0b013e318166af74

Seritan A, Asghar-Ali AA, Cooper R, Hatcher A. The time is now: climate change and aging adults' mental health. *American Journal of Geriatric Psychiatry.* 2023;31(3s):S21. https://doi.org/10.1016/j.jagp.2022.12.305

Shuler M, Suzuki S, Podesta A, Qualls-Hampton R, Wallington SF. A post-Hurricane Katrina examination of substance abuse treatment discharges with co-occurring psychiatric and substance use disorders. *Journal of Dual Diagnosis*. 2017;13(2):144-156. https://doi.org/10.1080/15504263.2016.1277816

Siegel C, Wanderling J, Laska E. Coping with disasters: estimation of additional capacity of the mental health sector to meet extended service demands. *Journal of Mental Health Policy and Economics*. 2004;7(1):29-35.

Silveira S, Kornbluh M, Withers MC, Grennan G, Ramanathan V, Mishra J. Chronic mental health sequelae of climate change extremes: a case study of the deadliest Californian wildfire. *International Journal of Environmental Research and Public Health*. 2021;18(4):1487. https://doi.org/10.3390/ijerph18041487

Sirey JA, Berman J, Halkett A, et al. Storm impact and depression among older adults living in Hurricane Sandy–affected areas. *Disaster Medicine and Public Health Preparedness*. 2017;11(1):97-109. doi:10.1017/dmp.2016.189

Slee A, Nazareth I, Bondaronek P, Liu Y, Cheng Z, Freemantle N. Pharmacological treatments for generalised anxiety disorder: a systematic review and network meta-analysis. *Lancet*. 2019;393(10173):768-777. doi:10.1016/S0140-6736(18)31793-8

Snyder M, Miles M, Hertz-Picciotto I, Conlon KC. Household needs among wildfire survivors in the 2017 Northern California wildfires. *Environmental Research Health*. 2025;3(1):015008. doi:10.1088/2752-5309/ad951c

Stukova M, Cardona G, Tormos A, et al. Mental health and associated risk factors of Puerto Rico Post-Hurricane María. *Social Psychiatry and Psychiatric Epidemiology.* 2023;58:1055-1063. https://doi.org/10.1007/s00127-023-02458-4

Substance Abuse and Mental Health Services Administration (SAMHSA). 2022-2023 National Surveys on Drug Use and Health (NSDUH): State-Specific Tables. Table 19A. February 27, 2025. Available at: https://www.samhsa.gov/data/sites/default/files/reports/rpt56188/2023-nsduh-sae-state-tables_0/2023-nsduh-sae-state-tabs-california.pdf. Accessed March 27, 2025.

Swiatek JL, Corcoran JP IV, Ramsey FV, Gentile NT. Six months after Maria: a post-hurricane examination of mental health and associated risk factors in older Puerto Ricans. *Journal of Emergency Management*. 2021;19(8):177-187. https://doi.org/10.5055/jem.0635

Taylor LK, Weems CF. Cognitive-behavior therapy for disaster-exposed youth with posttraumatic stress: results from a multiple-baseline examination. *Behavior Therapy*. 2011;42(3):349-363. doi:10.1016/j.beth.2010.09.001

Taylor SW, Woolford DG, Dean CB, Martell DL. Wildfire prediction to inform fire management: statistical science challenges. *Statistical Science*. 2013;28(4):586-615. https://doi.org/10.1214/13-STS451

To P, Eboreime E, Agyapong VIO. The impact of wildfires on mental health: a scoping review. *Behavioral Sciences*. 2021;11(9):126. https://doi.org/10.3390/bs11090126

University of California Merced Community and Labor Center. Farmworker Health in California: Health in a Time of Contagion, Drought, and Climate Change. 2023. Available at: https://clc.ucmerced.edu/sites/clc.ucmerced.edu/files/page/documents/fwhs_report_2.2.2383.pdf. Accessed April 7, 2025.

Valiente-Gomez A, Moreno-Alcazar A, Treen D, et al. EMDR beyond PTSD: a systematic literature review. *Frontiers in Psychology.* 2017;8:1668. doi:10.3389/fpsyg.2017.01668

Van Etten ML, Taylor S. Comparative efficacy of treatment for posttraumatic stress disorder: a meta-analysis. *Clinical Psychology and Psychotherapy*. 1998;5:126-144.

van Straten A, van der Zweerde T, Kleiboer A, Cuijpers P, Morin CM, Lancee J. Cognitive and behavioral therapies in the treatment of insomnia: A meta-analysis. *Sleep Medicine Reviews*. 2018;38:3-16. doi:10.1016/j.smrv.2017.02.001

Wettstein ZS, Vaidyanathan A. Psychotropic medication prescriptions and large California wildfires. *JAMA Network Open*. 2024;7(2):e2356466. doi:10.1001/jamanetworkopen.2023.56466

Word & Brown General Agency. Additional Resources to Aid Your Clients, Colleagues, and Others Needing Assistance Due to California Wildfires. 2025. Available at: https://www.wordandbrown.com/NewsPost/2025-California-Wildfire-Carrier-Information. Accessed April 6, 2025.

Xie Y, Zhu X, Wang L, et al. A network meta-analysis of psychological interventions for children and adolescents after natural and man-made disasters. *BMC Psychiatry*. 2024;24(1):468. doi:10.1186/s12888-024-05924-8.

Yue JL, Chang XW, Zheng JW, et al. Efficacy and tolerability of pharmacological treatments for insomnia in adults: a systematic review and network meta-analysis. *Sleep Medicine Reviews*. 2023;68:101746. doi:10.1016/j.smrv.2023.101746

Zhu Q, Zhang D, Wang W, et al. Wildfires are associated with increased emergency department visits for anxiety disorders in the western United States. *Nature Mental Health*. 2024;2:379-387. https://doi.org/10.1038/s44220-024-00210-8

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CHBRP assumes full responsibility for the report and the accuracy of its contents. All CHBRP bill analyses and other publications are available at chbrp.org.

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