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.

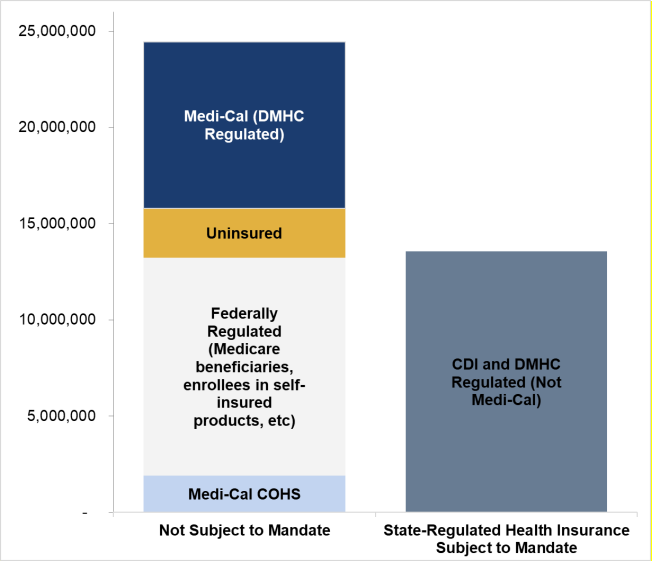
Bill Summary

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

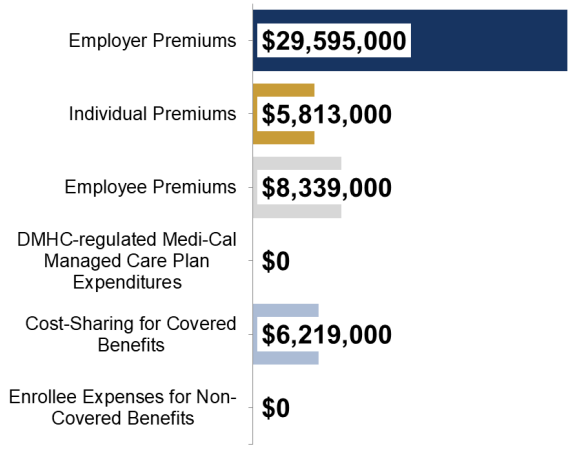
[1] Refer to CHBRP's full report for full citations and references.
[2] Although COHS plans are not subject to the Knox-Keene Act, DHCS generally updates Medi-Cal managed care plan contracts, All Plan Letters, and other appropriate authorities for alignment of managed care plan benefits, except in cases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