Sent Via Email Only

August 1, 2025

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

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

The Honorable Anna Caballero
Chair, Senate Appropriations Committee
1021 O Street, Suite 7620
Sacramento, CA 95814

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

Re: Letter to the 2024-25 California State Legislature on Assembly Bill 1032: Coverage for behavioral health visits, as amended on July 15, 2025

Dear Chairs Menjivar, Caballero, Bonta, and Wicks:

The California Health Benefits Review Program (CHBRP) was asked by the Assembly Speaker's staff on July 15, 2025, to provide a letter regarding Assembly Bill (AB) 1032, Coverage for behavioral health visits. CHBRP submitted an analysis of the bill in April of this year based on the February 20 bill language. This letter details the differences between the two bill versions and provides a fiscal estimate based on the amendments made to the bill on July 15, 2025. Appendix A contains detailed revised Benefit Coverage, Utilization, and Cost estimates and tables.

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 Language

As amended on July 15, 2025, AB 1032 would require state-regulated large group health plans and policies[2] to reimburse an eligible enrollee or insured for 12 visits per year with a behavioral health provider if the enrollee or insured is in a county where a local or state emergency has been declared due to wildfires and the enrollee or insured has experienced a loss, trauma, or displacement because of the fire. The February 20 version of the bill, as analyzed by CHBRP, would have required reimbursement for 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, with benefits lasting until 1 year from the date the local or state emergency is lifted, whichever is later. There are two primary differences between these bill versions:

- **Number of visits:** The July 15 version of AB 1032 requires reimbursement for 12 behavioral health visits in total, compared to the original version of the bill that allowed up to 12 behavioral health visits per year.
- **Duration of benefit coverage**: The July 15 version of the bill applies for the duration of a wildfire-related emergency declaration. Previously, benefits were mandated to be provided for one year following the end of an emergency declaration.
- **Coverage groups:** The July 15 version of the bill no longer applies to small group and individual market plans and now applies additionally to the California State Teachers Retirement System (CalSTRS).
- **Need for behavioral health visits**: The July 15 version of the bill requires that behavioral health visits must be used only in cases of loss, trauma, or displacement due to a wildfire. This is a narrower requirement than in the original version of the bill, which permitted use for anyone in a county affected by a wildfire.

Analytic Approach

CHBRP's approach and assumptions to calculate the updated fiscal impacts of AB 1032 as amended on July 15 are consistent with the approach taken in its previous analysis of AB 1032, published in April 2025.

Update in Expenditure Impacts

In its analysis of AB 1032, CHBRP estimated total net annual expenditures would increase by $49,966,000 for enrollees in state-regulated plans and policies. CHBRP's revised estimates of AB 1032, as amended on July 15, project an increase of **$18,393,000** in total annual expenditures; this estimate is $31,573,000 lower than CHBRP's previous estimated fiscal impact of the bill. See Appendix A of this letter for additional details on the analysis of benefit coverage, utilization, and expenditure estimates of the bill as amended on July 15.

The difference between the two estimates is due primarily to the reduction in number of projected utilizers of behavioral health visits, which is estimated to be 5,930 with the July 15 amendments compared with 16,170 with the original bill language. This is based on 1) a reduction in the estimated number of

[1] Refer to CHBRP's full report for full citations and references.
[2] Plans regulated by the Department of Managed Health Care (DMHC) and policies regulated by the California Department of Insurance (CDI).

enrollees with health insurance subject to AB 1032 and as a result, the number of enrollees in counties with a wildfire-related emergency declaration, and 2) reductions in the number of enrollees who use the benefit due to unmet need and those who use the benefit due to the wildfire.

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

Sincerely,

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

Appendix A. Benefit Coverage, Utilization, and Cost

This appendix provides details related to the fiscal analysis of AB 1032 as amended on July 15, 2025.

Benefit Coverage

If enacted, the July 15 version of AB 1032 would apply to the state-regulated plans offered through large group plans and policies including the California Public Employees' Retirement System (CalPERS), as well as members of the California State Teachers' Retirement System (CalSTRS) who receive a health care benefit under CalSTRS.

As shown in Table 1 below, CHBRP estimates for baseline coverage and postmandate coverage do not change due to the July 15 amendments. CHBRP estimates that 100% of enrollees have coverage for behavioral health visits both at baseline and postmandate. The number of enrollees with coverage for the mandated benefit is 9,212,000 with the July 15 amendments, compared with 13,570,000 with the original bill language.

Table 1: AB 1032 Impacts on Benefit Coverage, 2026

	Baseline (2026)	Postmandate Year 1 (2026)	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 AB1032	9,212,000	9,212,000	0
Percentage of enrollees with coverage for mandated benefit	0%	100%	100%
Number of enrollees with fully compliant coverage for mandated benefit	0	9,212,000	9,212,000

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.

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

Utilization

CHBRP estimates utilization of the proposed behavioral health visits benefit would be lower based on the July 15 amendments compared to the estimates based on the original bill language. Because fewer enrollees would be subject to AB 1032, fewer would be estimated to be in counties with a wildfire-related emergency declaration (3.0 million vs. 3.6 million) (Table 2).

At baseline, no enrollees have coverage as specified in AB 1032. Postmandate, CHBRP estimates the number of users of reimbursed behavioral health visits will total 5,930 with the July 15 amendments, compared with an estimated 16,170 based on the original bill language. This reduction is based on: 1) a smaller portion of enrollees with unmet needs is expected to use the benefit due to the amended language stating that the enrollee must have experienced a loss, trauma, or displacement because of the fire; and 2) fewer enrollees with wildfire-related needs are expected to use the benefit since coverage is limited to those in large groups.

Table 2: Impacts of AB 1032 on Utilization and Unit Cost, 2026

	Baseline (2026)	Postmandate Year 1 (2026)	Increase/ Decrease
Enrollees in counties with an emergency declaration due to wildfires	2,988,000	2,988,000	0
Utilizers of reimbursement for behavioral health	**0**	**5,930**	**5,930**
Wildfire related	0	4,240	4,240
Unmet need	0	1,690	1,690
Total reimbursed behavioral health visits	**0**	**71,060**	**71,060**
Wildfire related	0	50,840	50,840
Unmet need	0	20,220	20,220
Billed Cost per Visit	N/A	$240.00	$240.00

Source: California Health Benefits Review Program, 2025.

Expenditures

Postmandate, AB 1032 would result in increases in total premiums paid by employers and enrollees of DMHC-regulated plans and CDI-regulated policies of newly covered benefits. With the July 15 amendments, total employer-sponsored premiums would increase by $11,982,000 (0.02% increase), and total CalPERS employer premiums would increase by $1,461,000 (a 0.02% increase) (Table 3). Enrollee premiums (expenditures) would increase by $3,450,000 for enrollees with group insurance, a 0.02% increase. Enrollee out-of-pocket expenses would increase by $1,500,000. These numbers are lower than those estimated based on the original bill language, where CHBRP estimated: total employer-sponsored premiums would increase by $26,886,000 (0.04% increase), total CalPERS employer premiums would increase by $2,709,000 (a 0.03% increase), enrollee premiums (expenditures) would increase by $8,839,000 for enrollees with group insurance, a 0.04% increase, and enrollee out-of-pocket expenses would increase by $6,219,000

Table 3: AB 1032 Impacts on Expenditures, 2026

	Baseline (2026)	Postmandate Year 1 (2026)	Increase/ Decrease	Percentage Change
Premiums				
Employer-sponsored (a)	$68,752,638,000	$68,764,620,000	$11,982,000	0.02%
CalPERS employer (b)	$7,881,873,000	$7,883,334,000	$1,461,000	0.02%
Medi-Cal (excludes COHS) (c)	$31,818,731,000	$31,818,731,000	$0	0.00%
Enrollee Premiums (expenditures)				
Enrollees, individually purchased insurance	$21,757,790,000	$21,757,790,000	$0	0.00%
Outside Covered California	$6,011,399,000	$6,011,399,000	$0	0.00%
Through Covered California	$15,746,391,000	$15,746,391,000	$0	0.00%
Enrollees, group insurance (d)	$21,712,866,000	$21,716,316,000	$3,450,000	0.02%
Enrollee out-of-pocket expenses				
Cost-sharing for covered benefits (deductibles, copayments, etc.)	$18,992,422,000	$18,993,922,000	$1,500,000	0.01%
Expenses for noncovered benefits (e) (f)	$0	$0	$0	0.00%
Total Expenditures	$170,916,320,000	$170,934,713,000	$18,393,000	0.01%

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. About one in five (20.5%) of these enrollees has a pharmacy benefit not subject to DMHC. CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).
(c) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans. In addition, CHBRP is estimating 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

Table 4 and Table 5, below, 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 slightly by market segment.[3]

Postmandate, with the July 15 amendments, the changes in total premiums would range from increases of $0.15 PMPM for DMHC-regulated and CDI-regulated large group plans to an increase of $0.16 PMPM in DMHC-regulated

[3] Note that such changes are related to the number of enrollees (see Table 1, Table 4, and Table 5), with health insurance that would be subject to AB 1032.

CalPERS plans – all averaging a 0.02% increase. These represent lower increases compared to estimates from the original bill language, which ranged from $.22 PMPM to $.28 PMPM.

Enrollee Expenses

AB 1032–related changes in cost sharing for covered benefits (deductibles, copays, etc.) and out-of-pocket expenses for noncovered benefits would vary only slightly by market segment.[4]

Postmandate, for all plans that are covered, the changes in total enrollee expenses would increase by approximately $0.17 PMPM (0.02% increase). These are lower increases compared to estimates from the original bill language, which ranged from $.29 PMPM to $.34 PMPM.

[4] Note that such changes are related to the number of enrollees (see Table 1, Table 4, and Table 5) with health insurance that would be subject to AB 1032 expected to use the relevant tests, treatments, or services during the year after enactment.

Table 4. Baseline Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2026

	DMHC-Regulated						CDI-Regulated			
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Plans (by Market) (a)			
	Large Group	*Small Group*	*Individual*	*CalPERS (b)*	*Medi-Cal (excludes COHS) (c)*		*Large Group*	*Small Group*	*Individual*	**TOTAL**
					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 AB1032	8,034,000	0	0	914,000	0	0	264,000	0	0	9,212,000
Premium Costs										
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	$2,146,000
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.

Note: (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. About one in five (20.5%) of these enrollees has a pharmacy benefit not subject to DMHC. CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).

(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.

(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 includes 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

Table 5: Postmandate Change in Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2025

	DMHC-Regulated						CDI-Regulated			
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Plans (by Market) (a)			
	Large Group	*Small Group*	*Individual*	*CalPERS (b)*	Medi-Cal (excludes COHS) (c) *Under 65*	*65+*	*Large Group*	*Small Group*	*Individual*	**TOTAL**
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 AB1032	8,034,000	0	0	914,000	0	0	264,000	0	0	9,212,000
Premium Costs (postmandate change)										
Average portion of premium paid by employer (e)	$0.1207	$0.0000	$0.0000	$0.1332	$0.0000	$0.0000	$0.1095	$0.0000	$0.0000	$13,444,000
Average portion of premium paid by enrollee	$0.0315	$0.0000	$0.0000	$0.0258	$0.0000	$0.0000	$0.0403	$0.0000	$0.0000	$3,450,000
Total Premium	$0.1522	$0.0000	$0.0000	$0.1590	$0.0000	$0.0000	$0.1498	$0.0000	$0.0000	**$16,894,000**
Enrollee Expenses (postmandate change)										
Cost-sharing for covered benefits (deductibles, copays, etc.)	$0.0139	$0.0000	$0.0000	$0.0077	$0.0000	$0.0000	$0.0222	$0.0000	$0.0000	$1,500,000
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	$0.1662	$0.0000	$0.0000	$0.1667	$0.0000	$0.0000	$0.1720	$0.0000	$0.0000	**$18,393,000**
Postmandate Percent Change										
Percent change insured premiums	0.0217%	0.0000%	0.0000%	0.0185%	0.0000%	0.0000%	0.0180%	0.0000%	0.0000%	0.0111%
Percent change total expenditures	0.0217%	0.0000%	0.0000%	0.0177%	0.0000%	0.0000%	0.0180%	0.0000%	0.0000%	0.0108%

Source: California Health Benefits Review Program, 2025.

Note: (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. About one in five (20.5%) of these enrollees has a pharmacy benefit not subject to DMHC. CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).

(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.

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

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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