A REPORT TO THE 2025–2026 CALIFORNIA LEGISLATURE

Bill Analysis Report: California Assembly Bill 1843 Communicable Diseases: Hepatitis B and C

APRIL 13, 2026

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

chbrp.org

KEY FINDINGS

Analysis of California Assembly Bill 1843 Communicable Disease: Hepatitis B and C

Summary to the 2025-2026 California State Legislature, April 13, 2026

CHBRP

The version of California Assembly Bill (AB) 1843 analyzed by the California Health Benefits Review Program (CHBRP) would prohibit prior authorization requirements for direct-acting antiviral (DAA) medications that are medically necessary for the treatment of hepatitis C.

Background

Hepatitis C is a liver disease caused by infection from the hepatitis C virus (HCV). Individuals with hepatitis C can develop cirrhosis, liver cancer, and other liver- and non–liver-related complications and are at increased risk of premature death.

Benefit Coverage

Among the 13.2 million enrollees with a state-regulated pharmacy benefit, CHBRP estimates 5.7 million enrollees (43%) are in plans or policies out of compliance with AB 1843 due to prior authorization requirements, and 7.5 million enrollees (57%) are in plans or policies that are compliant. AB 1843 would not exceed essential health benefits (EHBs).

Medical Effectiveness

There is *very strong evidence* that DAAs are effective at treating hepatitis C, with cure rates above 95% for most medications. There is *strong evidence* that there is no difference in effectiveness among DAAs. There is also *strong evidence* that removing prior authorization requirements for DAAs improves health outcomes. There is *some evidence that* removing prior authorization requirements leads to increased utilization of DAAs and *not enough research* to determine whether removing prior authorization for DAAs improves health outcomes.

Cost Impacts

Among the 3,423 enrollees with a state-regulated pharmacy benefit that included prior authorization requirements at baseline who are diagnosed with hepatitis C within the first year, approximately 10% (or 342 enrollees) would receive DAAs. Postmandate, these enrollees would avoid an estimated 924 pretreatment tests and services per year from the removal of prior authorization requirements, resulting in an annual estimated decrease of $346 in costs per enrollee.

Furthermore, postmandate, CHBRP estimates the treatment rate for enrollees diagnosed with hepatitis C would increase to 11%, leading to 34 additional enrollees receiving DAAs to treat hepatitis C at a cost of $33,000 per course of treatment. Of these newly treated enrollees, 95% are estimated to be cured, reducing average annual costs associated with clinical complications of untreated hepatitis C by $7,650 per enrollee, resulting in the change in their expenses to range from a decrease of $895 to an increase of $644 depending on the market segment and plan design.

Total annual premiums would increase by $708,000, paid by employers and enrollees ($0.0020-$0.0134 per member per month). This premium increase applies to all enrollees regardless of whether they use the benefit. Aggregate cost sharing among enrollees who use DAAs would decrease by $40,000.

Public Health Impacts

CHBRP projects no measurable public health impact at the population level due to the small estimated increase in utilization. However, AB 1843 would likely yield health and quality-of-life improvements for the 34 additional enrollees using DAAs and the 342 enrollees avoiding pretreatment assessments no longer required under prior authorization. Barriers related to cost sharing and access to screening and treatment may remain.

Long-Term Impacts

Recent updates to HCV treatment guidelines have expanded eligibility, decreased requirements for testing and monitoring, and emphasized that HCV treatment can often be managed by nonspecialist providers. Increased uptake of the recently updated guidelines in conjunction with the removal of prior authorization is likely to increase the number of nonspecialists prescribing DAA therapy for patients with HCV infection, thereby increasing access to treatment and cure.

Table of Contents

Lists of Tables and Figures

Acronyms and Terminology

Acronyms

AASLD/IDSA – American Association for the Study of Liver Diseases/Infectious Diseases Society of America

AB – Assembly Bill

ACA – Affordable Care Act

CA – California

CalPERS – California Public Employees' Retirement System

CDC – Centers for Disease Control and Prevention

CDI – California Department of Insurance

CHBRP – California Health Benefits Review Program

COHS – County Organized Health System

DAA – direct-acting antiviral

DHCS – Department of Health Care Services

DMHC – Department of Managed Health Care

EHB – essential health benefits

FDA – U.S. Food and Drug Administration

HCC – hepatocellular carcinoma

HCV – hepatitis C virus

HIV – human immunodeficiency virus

SVR – sustained virologic response

USPSTF – U.S. Preventive Services Task Force

Terminology

CHBRP uses the following terminology for this analysis:

Hepatitis C: A liver disease caused by infection from the hepatitis C virus (HCV), which is transmitted through exposure to infected blood or bodily fluids containing infected blood.

Direct-acting antiviral (DAA) medications: An 8- to 12-week course of oral medications that treat and cure HCV infection.

Cirrhosis: Advanced, irreversible scarring of the liver that leads to liver failure.

Extrahepatic manifestations: Diseases affecting organs outside the liver, occurring in up to 74% of HCV patients.

Cost sharing: Payment for use of covered health insurance benefits is shared between the payer (e.g., health plan/insurer or employer) and the enrollee. Common cost-sharing mechanisms include copayments, coinsurance, and/or deductibles (but do not include premium expenses[1]).

Utilization management: Utilization management techniques are used by health plans and insurers to control costs, ensure medication compatibility, and manage safety. Examples include benefit coverage requirements related to prior authorization, step therapy, quantity limits, and limits related to the age or sex of the enrollee (such as prescription-only infant formula or prostate cancer screening for men).

Prior authorization:[2] Also known as precertification, prior approval, or prospective review, prior authorization is a utilization management technique commonly used by health insurance carriers to ensure that a given medical intervention meets the insurance plan or policy's criteria for coverage (Newcomer et al., 2017). Prior authorization was developed as a

[1] Premiums are paid by most enrollees, regardless of their use of any tests, treatments, or services. Some enrollees may not pay premiums for different reasons. For example, their employers cover the full premium, or they receive benefits through Medi-Cal.
[2] More information about prior authorization is available in CHBRP's 2023 analysis *Prior Authorization in California*.

tool for insurers to assess the appropriateness of treatment that would result in a hospital admission or a high-cost procedure (Resneck, 2020). The primary uses of prior authorization include:

- **Coverage evaluation:** Allows evaluation of whether a test, treatment, or service is medically necessary and otherwise covered.
- **Safety:** Acts as a safeguard to confirm that a patient's medications are compatible and provides an opportunity to check that proper diagnostic testing has been completed to ensure patient safety prior to use of a requested treatment. Prior authorization also reduces inappropriate patient care by stopping unsafe or low-value care that is inconsistent with the most recent clinical evidence.
- **Cost control:** Imposition of prior authorization for nonpreferred medications can encourage the use of preferred medications that can be procured at lower price.

Overview: AB 1843 and Hepatitis C

On February 12, 2026, the California Assembly Committee on Health requested that the California Health Benefits Review Program (CHBRP)[3] conduct an evidence-based assessment of the medical, financial, and public health impacts of Assembly Bill (AB) 1843, as amended on March 2, 2026, which would prohibit prior authorization for direct-acting antiviral (DAA) medications that are medically necessary for the treatment of hepatitis C.

Bill Language of AB 1843

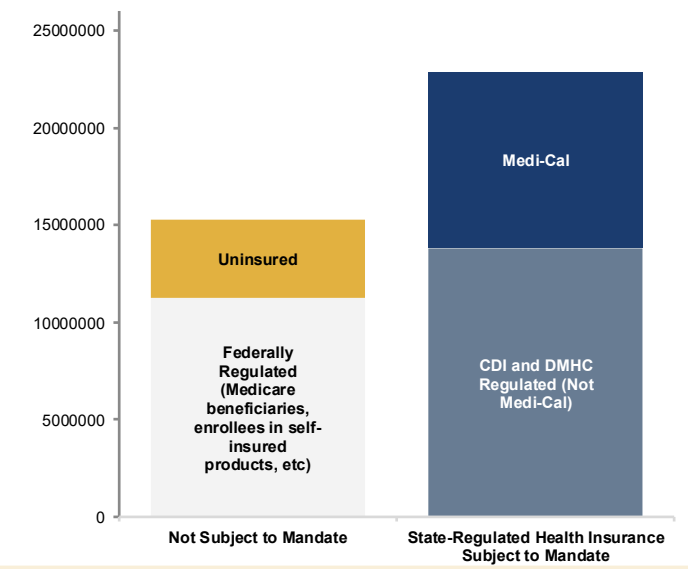
AB 1843 would prohibit prior authorization for DAAs that are medically necessary for the treatment of hepatitis C. If there is one or more FDA-approved therapeutic equivalent to a DAA to treat hepatitis C, only one version needs to be available without prior authorization.

Additionally, clinical criteria for hepatitis C treatment and prior authorization requirements[4] must align with the guidelines and standards of care consistent with the standards of the American Association for the Study of Liver Diseases and the Infectious Diseases Society of America. Prior authorization requirements cannot include requirements for patients to obtain the following before an insurer approves a prior authorization request:

(1) A liver biopsy
(2) Genotype testing
(3) Sobriety requirements
(4) Fibrosis staging thresholds
(5) Elastography or FibroScan documentation
(6) Ultrasound documentation
(7) A specialist referral or evaluation

See the full text of AB 1843 in CHBRP's Technical Brief on AB 1843, available on www.chbrp.org.

Figure 1. Health Insurance in CA and AB 1843



Source: California Health Benefits Review Program, 2026.
Note: CHBRP generally assumes alignment of Medi-Cal managed care plan benefits, with limited exceptions.
Key: CDI = California Department of Insurance; DMHC = Department of Managed Health Care.

If enacted, AB 1843 would apply to the health insurance of approximately 22,842,000 enrollees (60% of all Californians) (see Figure 1).

- **Includes**: Enrollees in commercial or CalPERS health insurance regulated by the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI), and Medi-Cal beneficiaries enrolled in DMHC-regulated plans and county organized health plans (COHS).

However, because DAAs are oral medications typically covered under the pharmacy benefit, CHBRP assumes AB 1843 would only impact enrollees with a state-regulated pharmacy benefit (approximately 13,157,000 Californians). For enrollees without a state-regulated pharmacy benefit, their coverage is considered compliant at baseline. However, should

[3] See CHBRP's authorizing statute.
[4] As stated in the first paragraph, prior authorization requirements would be permissible for a therapeutically equivalent DAA as long as one DAA is covered without prior authorization.

their health insurance plan or policy include a state-regulated pharmacy benefit in the future, those enrollees' coverage would be required to comply with AB 1843. See more information in the *Analytical Approach and Assumptions* section and CHBRP's Technical Brief on AB 1843.

It should be noted that DMHC regulates the plans and policies of approximately 74% of enrollees associated with CalPERS, and 80% of Medi-Cal beneficiaries, in addition to commercial enrollees.[5]

CHBRP provides an overview of common utilization management practices, including prior authorization, in its explainer *Utilization Management: An Overview*.

What Is Hepatitis C?

Hepatitis C is a liver disease caused by infection from the hepatitis C virus (HCV), which is transmitted through exposure to infected blood or bodily fluids containing infected blood. Acute hepatitis C occurs within the first 6 months of exposure to HCV; chronic hepatitis C occurs if acute hepatitis C is not recognized and treated and the virus is not cleared by the body within 6 months (CDC, 2025a). Studies estimate that acute hepatitis C leads to chronic infection in most patients (80-85%) (Basit and Koirala, 2025). The majority of individuals with acute and chronic hepatitis C are asymptomatic (Feld, 2026), and evidence suggests that one-third of people with hepatitis C are unaware of their infection status and can unknowingly transmit the virus to others (Lewis et al., 2023). Studies estimate that on average one person with HCV infection transmits the virus to 1 to 4 other people. (Scott et al., 2015; Ward and Hinman, 2019). HCV is primarily transmitted by sharing contaminated needles, syringes, or other equipment used to prepare or inject drugs; other risk factors for transmission include multiple sexual partners, nonprofessional tattoo or piercing, prior incarceration, workplace exposure to needle sticks, or being born to an HCV-infected woman (Ghany and Morgan, 2020). Individuals with hepatitis C can develop cirrhosis (advanced, irreversible scarring of the liver that leads to liver failure), liver cancer (hepatocellular carcinoma [HCC]), and other liver- and non-liver–related complications and are at increased risk of premature death (CDC, 2024; CDC, 2025a).

- **Prevalence:** Approximately 2.4 to 4.0 million people in the United States have hepatitis C (Hall et al., 2025).
    - **Acute hepatitis C:** In 2023, the Centers for Disease Control and Prevention (CDC) found that there were 4,966 new reported cases of acute hepatitis C nationwide, but estimates new acute HCV infections at 69,000 after adjusting for underascertainment and underreporting[6] (CDC, 2025b).
    - **Chronic hepatitis C:** Based on California Department of Public Health (CDPH) data from 2018 (the most recent statewide surveillance data available), the annual rate of newly reported cases of chronic hepatitis C is estimated at 89 cases per 100,000 population in California (about 35,500 cases), which is a 10% decrease from 2017 (CDPH, 2020).
- **Mortality:** According to 2023 CDC data, there were 11,194 deaths with hepatitis C listed as a cause of death in the United States (2.52 deaths per 100,000 population) (CDC, 2025b).

The presence of hepatitis C in United States has direct and indirect economic and societal costs, with estimates of the direct costs of hepatitis C in the United States exceeding $10 billion (Stepanova and Younossi, 2017). Additionally, individuals with hepatitis C experience significantly more sick leave, short-term disability, and long-term disability compared to those without hepatitis C (Su et al., 2010).

[5] For more detail, see CHBRP's resource *Sources of Health Insurance in California*.
[6] Underascertainment of HCV occurs because the infection is often asymptomatic as well as challenges with hepatitis C surveillance reporting, such as incomplete clinician reporting, delayed data capture, and restrictive case surveillance definitions (Onofrey et al., 2015). To account for underascertainment and underreporting, the CDC uses a previously published probabilistic model for estimating the true incidence of hepatitis C from reported cases (Klevens et al., 2014).

Screening and Treatment for Hepatitis C

The American Association for the Study of Liver Diseases (AASLD)/Infectious Diseases Society of America (IDSA), the CDC, and the U.S. Preventive Services Task Force (USPSTF) recommend universal one-time HCV screening for adults aged 18 years and older (Ghany and Morgan, 2020; Owens et al., 2020; Schillie et al., 2020). For individuals with HCV infection, the AASLD/IDSA guidelines include simplified HCV treatment algorithms for treatment-naïve adults (i.e., adults who have never been treated) without cirrhosis. These simplified algorithms streamline initiation of antiviral treatment by decreasing requirements for pretreatment assessments for uncomplicated patients (Bhattacharya et al., 2023) and are intended to be used by any health care provider knowledgeable about HCV disease and treatment as long as they can consult a specialist if needed (Ghany and Morgan, 2020). Although the guidelines continue to recommend interventions and lifestyle changes to prevent further liver damage, they no longer condition initiation of antiviral therapy on abstinence from alcohol or sobriety testing, genotype testing, or other tests for cirrhosis (e.g., transient elastography, prior liver biopsy). As guidelines have continued to evolve, prior authorization requirements have not kept pace with updated guidelines by continuing to require pretreatment assessments. Pretreatment assessments commonly required as part of prior authorization requirements include:

- Liver biopsy – a medical procedure to remove a small piece of liver tissue for lab analysis; used to diagnose liver problems, to determine the extent of liver scarring (called fibrosis), and to predict risk of progression to liver failure (Chopra, 2025).
- Genotype testing – a blood test that identifies genetically distinct strains of HCV and can help guide which medication to use for hepatitis treatment (VA, n.d.).
- Sobriety requirements – a policy requiring abstinence from alcohol or illicit drug use for a period of time, usually 6 months.
- Fibrosis staging thresholds – Fibrosis is scarring of the liver due to chronic liver injury. Staging identifies the degree of fibrosis. Liver fibrosis is staged on the basis of severity: no fibrosis (F0), mild fibrosis (F1), significant fibrosis (F2), advanced fibrosis (F3), and cirrhosis (F4). There are multiple noninvasive methods for assessing liver fibrosis. These include blood tests (such as the FIB-4 score) and imaging of liver stiffness (called elastography). Noninvasive liver staging techniques have thresholds to help rule-in or rule-out significant fibrosis or cirrhosis (Castera et al., 2025; Kisseleva, 2017).
- Elastography or FibroScan documentation – Elastography is a measurement of liver stiffness using either specialized ultrasound or magnetic resonance. FibroScan is a specific type of ultrasound elastography device that is widely used (Castera et al., 2025).
- Ultrasound documentation – An ultrasound is an imaging test that uses sound waves to make pictures of organs, tissues, and other structures inside the body; and
- A specialist referral or evaluation.

After FDA approval of a new point-of-care HCV RNA[7] test in 2024 (FDA, 2024), in 2025, the AASLD/IDSA released a new "test and treat" algorithm that limits the provider assessment to a review of signs, symptoms or history of liver disease, blood tests, and review of potential medication interactions. Patients immediately begin treatment with one of the first-line medications, without the need for additional tests before treatment initiation (AASLD/IDSA, 2025).

The AASLD/IDSA guidelines recommend DAA treatment for all adults with acute or chronic HCV infection (except for individuals with short life expectancy) (Ghany and Morgan, 2020). There are currently five DAA treatments available.[8]

[7] HCV ribonucleic acid (RNA) is the genetic material of the hepatitis C virus.
[8] The five medications are: (1) glecaprevir/pibrentasvir (Mavyret); (2) sofosbuvir/velpatasvir (Epclusa); (3) sofosbuvir/velpatasvir/voxilaprevir (Vosevi); (4) ledipasvir/sofosbuvir (Harvoni); and (5) elbasvir/grazoprevir (Zepatier).

Typical treatment duration is 8 to 12 weeks; some patients with decompensated cirrhosis[9] receive treatment for 24 weeks. Two DAAs are pangenotypic (i.e., applicable to any HCV genotype and genotype testing is not required to initiate treatment) and considered first-line treatment. The goal of HCV treatment is to achieve sustained virologic response (SVR), which indicates that the infection is gone (virologic cure).

Screening and treatment rates

Studies have found that only 15% to 20% of eligible patients (and 25% of high-risk patients) receive HCV screening; (Ferval-Shioya et al., 2025; Kasting et al., 2018; Linas et al., 2014). Additionally, even though antiviral therapy for hepatitis C is nearly universally effective (see more information below in *How Effective Are Treatments for Hepatitis C?*), treatment rates remain low for both adults and children with HCV infection (as high as 35% for HCV infected adults and 12-14% for HCV infected children) (Curtis et al., 2025; Epstein et al., 2024; Ghany et al., 2025; Thompson et al., 2022).

Despite recommendations for universal HCV screening, studies have found delays in diagnosis and linkage to treatment for patients with HCV. A large national cohort study identified delayed diagnosis in an estimated 90% of patients with chronic hepatitis C and 75% of patients experienced liver complications, despite availability of DAA treatment during the study period. Approximately 48% of patients were diagnosed with hepatitis C in the 6 months prior to their first occurrence of a liver-related complication; the authors posit that these patients were "only tested to work up the etiology of their liver complications." This study also found that the majority of hepatitis C patients started DAA treatment after a liver complication had occurred and only 6% of nondelayed diagnosis patients started DAA treatment more than 2 years before liver complications occurred (Levesley et al., 2025). One study of patients in a large hepatitis C cohort found that a majority of patients already had advanced liver disease at the time of their initial HCV infection diagnosis, despite several years of prior health care engagement (Moorman et al., 2015). Taken together, these findings suggest that the new simplified treatment algorithms and test-and-treat services may help identify enrollees with HCV infection earlier and initiate treatment in a more timely manner, increasing the percentage of people who clear infection and preventing disease complications.

Disparities and Barriers to Accessing Hepatitis C Screening and Treatment

Research has identified disparities in HCV risk perception, testing, and linkage to care. In California, rates of newly reported cases of hepatitis C are higher among men and individuals aged 15 to 39 years (CDPH, 2020a). People of color (especially Black and American Indian/Alaska Native children and adults) are less likely to complete HCV testing, less likely to be prescribed antiviral therapy, and experience higher mortality rates due to hepatitis C compared to other racial/ethnic groups (Ahlers et al., 2025; Ahmed et al., 2025; Curtis et al., 2025; Elnaiem et al., 2025; Epstein et al., 2024). Studies have also found that the rate of hepatitis C infection is higher among persons experiencing poverty or homelessness and among persons with public insurance or who are uninsured (Elnaiem et al., 2025; Lewis et al., 2023).

Barriers at the patient and system level contribute to the relatively low screening and treatment rates for hepatitis C. At the patient level, stigma, limited health literacy about HCV, and limited access to primary care contribute to decreased HCV screening and treatment (Alenzi and Almeqdadi, 2024; Baumert et al., 2019). At the system level, studies have found that most HCV treatment continues to be handled primarily by specialists (Kapadia et al., 2021; Scialli et al., 2024), and primary care providers cite several barriers to their providing HCV care, including inadequate training in hepatitis C management, lack of familiarity with hepatitis C guidelines, and insurance or institutional restrictions on hepatitis C treatment (Javanbakht et al., 2020; Loomis et al., 2025; Wang et al., 2022).

For an in-depth look at clinical guidance, existing disparities, and barriers to access to care for hepatitis C, please see the *Background on Hepatitis C* in CHBRP's Technical Brief on AB 1843.

[9] Decompensated cirrhosis is an advanced stage of liver disease where, due to extensive scarring, the liver can no longer function properly, leading to life-threatening complications.

How Effective Are Treatments for Hepatitis C?

CHBRP's medical literature review focused on determining the effectiveness of treatment of hepatitis C virus infection with DAAs on health outcomes, processes of care, and utilization of other health services. Additionally, this review examined the impact of utilization management, including prior authorization, on utilization of DAAs and health outcomes.

The most significant indicator of the effectiveness of DAAs is the percentage of patients formally cured of hepatitis C, defined as having a sustained virologic response (SVR) at 12 weeks after treatment ends (SVR12), meaning the virus is undetectable following a blood test. Health outcomes included mortality and liver-related morbidity including liver cancer. CHBRP also assessed the effects of DAAs on extrahepatic manifestations, which are diseases, symptoms, or conditions caused by the HCV infection that occur outside the liver. These systemic issues impact organs like the skin, kidneys, joints, and nervous system, often the first sign of underlying liver infection. Harmful side effects considered included mild adverse events, such as fatigue and headache, as well as severe adverse events.

See the *Medical Effectiveness* section of CHBRP's Technical Brief on AB 1843 for definitions of terms used to grade the strength of evidence about the effect of a test, treatment, or service.

Effectiveness of DAA Medications at Curing Hepatitis C

Figure 2. Level of Evidence of Effectiveness of DAAs at Curing Hepatitis C

There is *very strong evidence*[10] that DAAs are effective at curing hepatitis C based on nine meta-analyses that encompassed both clinical trials and observational studies (Figure 2). Across the studies, all DAAs consistently achieved high cure rates, with SVR12 exceeding 95%, the established standard for virologic cure.

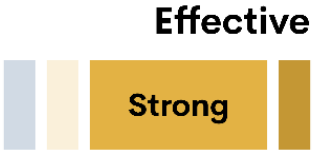
In special populations, SVR12 remains high, ranging from 94.0% to 97.8% in patients with HCV who are also infected with HIV, depending on which medication is used. In patients with HCV who have cirrhosis of the liver, pooled SVR12 was 95.0% to 99.4% (depending on the severity of the cirrhosis).

There is *strong evidence*[11] there is no difference in effectiveness in achieving curative SVR12 rates between different DAAs based on five systematic reviews and meta-analyses.

There is *very strong evidence* that the harms such as serious adverse events and deaths from DAAs are rare, based on five meta-analyses. One rare but serious harm of DAAs is the potential reactivation of chronic hepatitis B virus (HBV) to an active state among people also infected with hepatitis B. This risk can be reduced by treating HBV before the use of DAAs. The most common reported adverse events were headaches, fatigue, and pruritus (itchy skin).

Effectiveness of DAA Medications on Health Outcomes and Utilization of Health Services

Figure 3. Level of Evidence of Effectiveness of DAAs on Health Outcomes

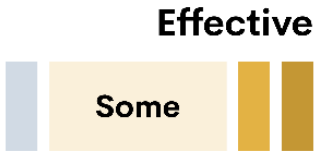


There is *strong evidence* that DAAs improve health outcomes based on two studies (one randomized controlled trial and one retrospective cohort study) and one meta-analysis (23 studies) and that the risk of decompensated cirrhosis, liver cancer, and chronic kidney disease/end-stage kidney disease, stroke, major adverse cardiac events, and neurocognitive disorders is lower in people who achieve SVR than in those who do not (Figure 3).

[10] *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.
[11] *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.

There is *some evidence*[12] that DAAs reduce the utilization of health services, specifically hospitalization, based on three studies. Untreated HCV infection was linked to higher hospitalization risk while treatment with DAA reduced hospitalizations, including a reduction in liver-related admissions among U.S. patients with HCV cirrhosis (Figure 4).

Figure 4. Level of Evidence of Effectiveness of DAAs on Utilization of Health Services



Impact of Prior Authorization

Few studies have examined the impact of prior authorization or other utilization management policies on use of hepatitis C medications and the subsequent health outcomes. There is *some evidence* to suggest that prior authorization or other utilization management policies for DAAs affect utilization of DAAs based on two observational studies (Figure 5). There is *not enough research* to determine whether prior authorization or other utilization management policies for DAAs affect health outcomes (Figure 6).

Figure 5. Level of Evidence of Effectiveness of Prior Authorization on Utilization of DAAs

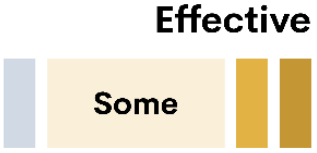


Figure 6. Level of Evidence of Effectiveness of Prior Authorization on Health Outcomes

Policy Context

Existing California Law and Regulations

Current California law requires coverage of medically necessary prescription medications by plans and policies that cover outpatient prescription medications.[13] Additionally, DMHC-regulated plans and large-group CDI-regulated policies are required to cover medically necessary Basic Health Care Services, including hospital inpatient services and ambulatory care services.[14]

Medi-Cal

California, in addition to 33 other states, does not have prior authorization requirements for hepatitis C treatments for Medicaid beneficiaries for the initial treatment (CHLPI, 2026).

Prior authorization

When health plans and policies have benefit provisions that require obtaining prior authorization, California law requires those plans and policies to notify a prescribing provider of its coverage determinations within 72 hours of nonurgent requests or within 24 hours if exigent circumstances exist for medications covered under the pharmacy benefit.[15] For services covered under the medical benefit, insurers must make determinations within 5 business days, or within 72 hours if an enrollee faces imminent and serious threat to their health.[16] These time requirements are dependent upon the plan or policy receiving all necessary information and the enrollee and clinician completing any necessary tests prior to submitting the request.

Cost sharing

There are existing laws in California that limit cost sharing for prescription medications for a majority of Californians with state-regulated pharmacy benefits.[17] In particular, cost sharing per prescription for covered outpatient prescription drugs for a supply of up to 30 days shall not exceed $250 (copays, coinsurance after any applicable deductible).[18] However, this

[12] *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.
[13] INS §10123.201.
[14] INS §10112.281.
[15] HSC §1367.241 and INS §10123.191.
[16] HSC §1367.01 and INS §10123.135.
[17] See more information in CHBRP's Issue Brief *Outpatient Prescription Drug Cost Sharing.*
[18] HSC §1342.73; INS §10123.1932.

statute has different terms for enrollees in plans/policies with an actuarial value at or equivalent to bronze level and high deductible health plans/policies (HDHPs).

Federal Preventive Services Requirements

The USPSTF provides a B recommendation, as of March 2020, for screening for hepatitis C virus infection in asymptomatic adults aged 18 to 79 years, meaning this test is required to be covered without cost sharing for enrollees in most plans and policies. See more information in CHBRP's Technical Brief on AB 1843 about requirements for plans and policies in California to cover preventive services without cost sharing.

Essential Health Benefits and the Affordable Care Act

Because AB 1843 would result in changes in terms of covered benefits versus requiring new benefit coverage, AB 1843 would not exceed the current definition of EHBs in California.

Similar Legislation in Other States

CHBRP has not identified similar legislation or laws that prohibit prior authorization for DAAs to treat hepatitis C for commercial or state employee health plans in other states.

Back to Table of Contents

Analytic Approach and Assumptions

CHBRP analyzes bills in the current environment given current law and regulations at both the state and federal levels. All estimates are based on current data and do not take into consideration any future or potential changes to factors that may influence the impacts of AB 1843, unless otherwise specifically mentioned.

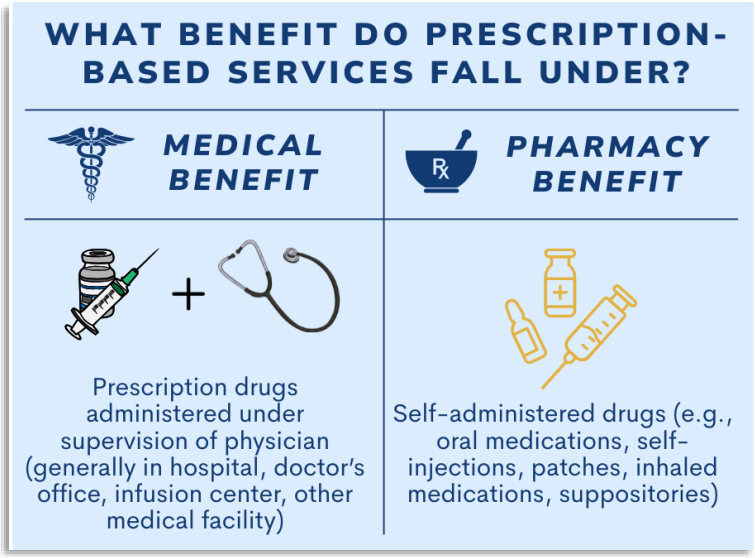
Language Interpretation

CHBRP made the following assumptions based on the language of AB 1843:

- Plans and policies would only need to cover one therapeutic equivalent DAA without prior authorization if there are multiple versions of a medication available (i.e., a brand-name and a generic version). CHBRP assumes therapeutic equivalency is determined in accordance with the FDA's definition of equivalency. Criteria include requirements that medications (a) contain identical amounts of the identical active drug ingredient in the identical dosage form and route of administration, and (b) meet compendial or other applicable standards of strength, quality, purity, and identity (FDA, 2026).
- AB 1843 would not require plans and policies to provide on-formulary coverage of ***all*** direct-acting antivirals that treat hepatitis C, although California state law does require coverage of medically necessary prescription medications.

Pharmacy Benefit Coverage

- As of January 1, 2022, outpatient prescription drugs are covered on a fee-for-service basis by DHCS for all Medi-Cal beneficiaries through the Medi-Cal Rx program.[19] Their pharmacy benefit is "carved out" of the coverage provided by Medi-Cal managed care plans, and so AB 1843 would not be expected to impact the benefit coverage of Medi-Cal beneficiaries.
- DAAs that treat hepatitis C are typically covered under the pharmacy benefit. Therefore, CHBRP has focused this analysis on medications covered under the pharmacy benefit, although AB 1843 would also prohibit prior authorization for medications used to treat hepatitis C that are covered under the medical benefit.



Cost-Related Analytical Approach and Assumptions

This analysis reports the estimated incremental impact of full-scale implementation of AB 1843 on benefit coverage, utilization, and cost for a single year.[20] Full-scale implementation typically requires a "ramp up" period, which may include educating enrollees, providers, and insurers on the new benefits or coverage; updating procedures and policies; and increasing provider capacity for marginal utilization resulting from AB 1843. Furthermore, some policies may have staggered

[19] For more on outpatient prescription drug coverage among Californians with state-regulated health insurance, see CHBRP's resource *Pharmacy Benefit Coverage in State-Regulated Health Insurance*.

[20] For some analyses, impacts as a result of changes to health insurance benefits may occur over multiple years (e.g., impacts in pregnancy and childbirth rates resulting from changes to utilization of fertility services, staggered implementation, or long-term changes in utilization). CHBRP's estimates represent the full impact of the mandate in one year even if changes in coverage, utilization offsets, and costs may be realized in more than one year.

implementation or longer-term changes in utilization. The incremental impact estimates below assume there is no "ramp up" period and represent ongoing annual costs at full-scale implementation of AB 1843, including potential short-term offsets. CHBRP further assumes that state and industry policies and provider and patient behaviors would remain constant throughout the time period it takes for the full impact of the bill to be realized.[21] For a discussion of long-term impacts of AB 1843, see the *Long-Term Impacts* section.

Further details about the data sources, approach, and key assumptions used to analyze AB 1843 are available in CHBRP's Technical Brief on AB 1843.

Approach and Assumptions on Baseline Coverage and Utilization

- CHBRP assumes that 10% of patients diagnosed with hepatitis C are treated with DAA drugs at baseline based on estimates from Milliman's proprietary 2024 Consolidated Health Cost Guidelines™ Sources Database (CHSD), two national studies (Ghany et al., 2025; Thompson et al., 2022), and expert opinion. See more information in CHBRP's Technical Brief on AB 1843.

Approach and Assumptions on Postmandate Coverage and Utilization

- CHBRP assumes utilization of DAA drugs would increase by 10% (or from 10% to 11%) among enrollees in plans or policies with prior authorization requirements at baseline because of the removal of these requirements. This estimate is based on Milliman's Prescription Drug Rating Model, a Milliman prior authorization report (Busch and McCarthy, 2025), and expert opinion. See more information in CHBRP's Technical Brief on AB 1843.
- Enrollees in plans and policies without prior authorization at baseline (and, therefore, those who are in compliant plans or policies at baseline) would not experience an increase in utilization.
- In estimating the cost impacts of AB 1843, CHBRP assumes that plans and policies with an outpatient pharmacy benefit would continue their current cost-sharing requirements and that DAAs would continue to be subject to cost sharing under the specialty tier, typically as coinsurance.[22] CHBRP also assumes that plans and policies would continue their current cost-sharing requirements under the respective medical benefits.

Offsets

CHBRP uses the term "cost offset" to describe the amount of medical care costs that may not occur as a result of the use of another covered benefit. For this analysis, CHBRP uses the following assumptions in three pathways for utilization and cost offsets.

- For the plans or policies that have prior authorization at baseline, those requirements typically include each of the categories prohibited in AB 1843 (i.e., liver biopsies, genotype testing, fibrosis staging thresholds, elastography or fibroscans, ultrasounds, and specialist referrals), except for sobriety requirements. CHBRP assumes that utilization would be reduced for some tests and services prior to prescribing DAAs to treat hepatitis C, while the frequency of other tests and services would not change. The following assumptions are based on expert opinion, including the content expert for AB 1843 and two California-based physicians who treat patients with hepatitis C. Baseline rates of the tests are estimated for patients treated with DAAs for hepatitis C using Milliman CHSD. CHBRP assumes the utilization of genotype testing would decrease from a baseline rate of 49% to a postmandate rate of 25% because many of the DAA drugs are pangenotypic. Similarly, CHBRP assumes the utilization of ultrasounds would decrease from a baseline rate of 74% to a postmandate rate of 25% because routine blood tests would be used to determine whether an ultrasound was medically necessary, consistent with the updated AASLD/IDSA guidelines. Furthermore, CHBRP assumes referrals to specialists would decrease from a baseline rate of 73% to a postmandate rate of 25%

[21] CHBRP's Cost and Coverage Model also assumes enrollees maintain one form of health insurance for the entire calendar year. Examples of state and industry policies and behavior include medications that may be developed or approved in the future, health insurance market changes beyond what is known at the time of publication of this analysis, and statutory changes resulting from other health benefit mandates.
[22] See more information in CHBRP's Issue Brief *Outpatient Prescription Drug Cost Sharing.*

because the updated AASLD/IDSA guidelines recommend treatment immediately and primary care providers with knowledge of hepatitis C or access to a specialist are able to treat patients with hepatitis C. In contrast, CHBRP assumes the utilization of elastography (to determine fibrosis staging thresholds) and liver biopsies would not change because the baseline rates among diagnosed patients were relatively low at 17% and 1%, respectively.

- Because of the 95% cure rate of DAA drugs to treat hepatitis C, CHBRP assumes costs associated with hepatitis C–related complications would decrease by $7,650 per year for 95% of the additional patients treated as a result of AB 1843 (Kaplan et al., 2022; Nyberg et al., 2023; WHO, 2025). See more information in CHBRP's Technical Brief on AB 1843.
- Although additional use of DAA drugs to treat hepatitis C will prevent transmission of the disease to others — resulting in lower health care utilization — the effect could not be quantified because a reliable transmission rate could not be found for the commercially insured population (the primary population subject to the bill). Furthermore, the effect would likely be small because of the relatively small number of additional patients who would be treated as a result of AB 1843.

For further details on the underlying data sources, methods, and assumptions used in this analysis please see the technical brief for this report, entitled "Technical Brief: AB 1843," available at www.chbrp.org.

Back to Table of Contents

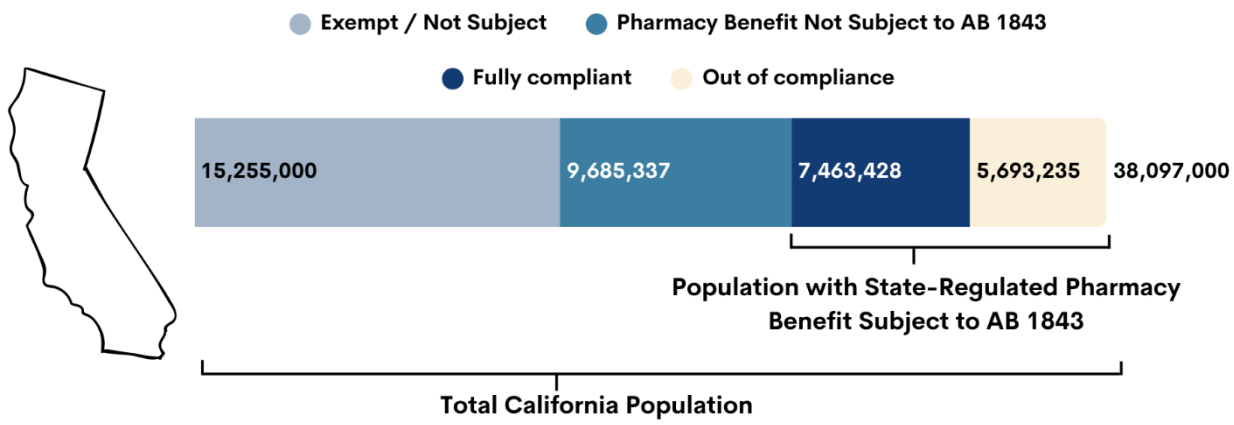
AB 1843 Impacts: Benefit Coverage and Cost

Benefit Coverage

All enrollees with a pharmacy benefit regulated by DMHC or CDI have on-formulary coverage for at least two DAAs at baseline. Of these 13,156,663 enrollees, CHBRP estimates 5,693,235 (43%) are enrolled in plans or policies out of compliance with AB 1843 at baseline due to prior authorization requirements, and 7,463,428 (57%) are enrolled in plans or policies that are compliant (Figure 7). As stated before, for the plans or policies that have prior authorization at baseline, those requirements typically include each of the categories prohibited in AB 1843 (i.e., liver biopsies, genotype testing, fibrosis staging thresholds, elastography or fibroscans, ultrasounds, and specialist referrals), except for sobriety requirements. Furthermore, these plans or policies also tend to have quantity limitations and re-treatment restrictions.

Postmandate, 100% of enrollees would have coverage compliant with AB 1843. Please note that CHBRP's approach is to assume full compliance postmandate on the part of all health insurance subject to the proposed mandate. For additional details on impacts to benefit coverage, see Table 6 in the Appendix.

Figure 7. California Health Insurance and Baseline Compliance With AB 1843



Source: California Health Benefits Review Program, 2026.
Note: The coverage of enrollees in state-regulated plans and policies but without a state-regulated pharmacy benefit (i.e., Medi-Cal beneficiaries and some CalPERS and commercial enrollees) is considered compliant at baseline.

Utilization and Unit Cost

Table 1 provides estimates of the impacts of AB 1843 on utilization and unit cost of DAAs to treat hepatitis C. At baseline, 7,852 enrollees are diagnosed with hepatitis C, of whom, 3,423 are covered by a plan or policy with prior authorization requirements, including 342 enrollees (or 10%) who use DAAs to treat the condition. Some of these 342 enrollees may access treatment sooner in Year 1 because of the removal of prior authorization requirements and associated testing, but this cannot be quantified. Postmandate, 34 additional enrollees (representing a 10% increase) would use DAAs to treat the condition.

At baseline and postmandate, the average unit cost for a course of DAA treatment is $33,000, which includes an average enrollee cost share of $1,094. The cost share depends on the particular DAAs being used to treat hepatitis C and the plan's or policy's coinsurance, deductible, and out-of-pocket maximum for its pharmacy benefit. The annual avoided costs per newly treated enrollee for complications associated with untreated hepatitis C is $7,650. The annual avoided unit cost

of the genotype test, ultrasound, and specialist visit is $346 per treated enrollee, which is based on average unit cost for the three types of utilization, weighted for assumed use. These avoided costs affect both premiums and cost sharing.

Table 1. Impacts of AB 1843 on Utilization and Unit Cost, 2027

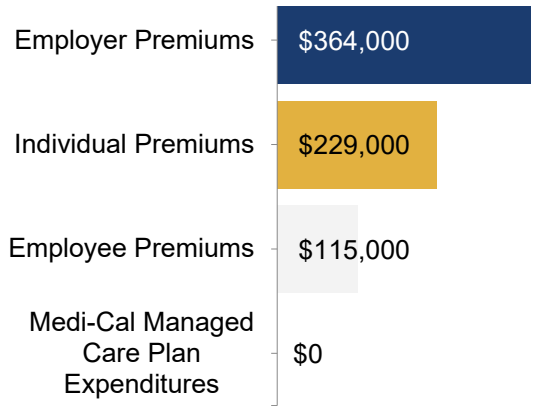
	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Eligible populations and utilization				
Total number of enrollees with a hepatitis C diagnosis at baseline	7,852	7,852	0	0.00%
Number of enrollees with a hepatitis C diagnosis with prior authorization requirements at baseline	3,423	3,423	0	0.00%
Number of enrollees with a hepatitis C diagnosis without prior authorization requirements at baseline	4,429	4,429	0	0.00%
Total number of enrollees using DAAs for hepatitis C at baseline	785	819	34	4.36%
Number of enrollees using DAAs for hepatitis C with prior authorization requirements at baseline	342	376	34	10.00%
Number of enrollees using DAAs for hepatitis C without prior authorization requirements at baseline	443	443	0	0.00%
Number of genotype tests performed for enrollees using DAAs	385	205	(180)	-46.76%
Number of liver ultrasounds performed for enrollees using DAAs	581	205	(376)	-64.74%
Number of specialist visits for enrollees using DAAs	573	205	(368)	-64.26%
Unit costs				
Average cost of treatment per course of DAA for hepatitis C (a)	$33,000	$33,000	$0	0.00%
Average cost sharing for DAAs for hepatitis C per treated enrollee with hepatitis C	$1,094	$1,094	$0	0.00%
Average annual cost of avoided complications per newly treated enrollee with hepatitis C	$0	$7,650	$7,650	
Average annual cost of avoided testing and specialist visits per treated enrollee with hepatitis C (b)	$0	$346	$346	

Source: California Health Benefits Review Program, 2026.
Notes: (a) Within this average, unit costs range from $30,000 to $38,000.
(b) Avoided testing includes genotype and ultrasound tests.
Key: DAA = direct acting antiviral.

Expenditures and Premium Impacts

Policies affecting health insurance benefits, such as benefit coverage mandates or utilization management restrictions, have the same impact on premiums for all enrollees, regardless of whether they use the benefit because even enrollees who do not use the benefit pay the increase in premiums as members of the overall risk pool. For cost sharing, enrollees can generally be grouped into two categories: enrollees who utilize the benefit and those who do not, with the utilizers being responsible for paying cost sharing related to the benefit, net of cost sharing offsets from reduced utilization related to the benefit.[23]

Figure 8. Premium Impacts of AB 1843 on Employers and Enrollees



Source: California Health Benefits Review Program, 2026.

Expenditure Impacts on Employers and All Enrollees

As shown in Figure 8, for DMHC-regulated plans and CDI-regulated policies, AB 1843 would increase total annual premiums paid by employers and enrollees by approximately $708,000, which incorporates approximately $500,000 in cost offsets. For more details, see **Error! Reference source not found.** in the Appendix. The premium impact is the same for all enrollees, regardless of whether they use the benefit. Changes in premiums as a result of AB 1843 would vary by market segment, for example, ranging from $0.0020 to 0.0134 per member per month in commercial plans and policies (Table 2; see also Table 7 and Table 8 in Appendix).

Table 2. Premium Impact Ranges of AB 1843 by Market Segment

Market Segment	Premium Impact Range (PMPM)
Commercial plans/policies	$0.0020 – $0.0134
Covered California – individually purchased	$0.0075
CalPERS	$0.0041
Medi-Cal	$0.0000

Source: California Health Benefits Review Program, 2026.
Key: CalPERS = California Public Employees' Retirement System; PMPM = per member per month.

Below, Table 3 provides estimates of the aggregate impacts of AB 1843 on premiums, resulting in a total employer and enrollee premium increase of $708,000 (or 0.0004%).

[23] Depending on their health insurance and the benefit in question, enrollees may or may not also pay for the benefit. For example, most Medi-Cal beneficiaries do not have cost sharing and do not pay health insurance premiums, whereas enrollees with health insurance in the individual market may pay both insurance premiums and cost sharing or other out-of-pocket expenses.

Table 3. Impacts of AB 1843 on Premiums, 2027

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Non-enrollee premiums				
Employer-sponsored (a)	$75,730,916,000	$75,731,242,000	$326,000	0.0004%
CalPERS employer (b)	$8,611,855,000	$8,611,893,000	$38,000	0.0004%
Medi-Cal (c)	$42,982,384,000	$42,982,384,000	$0	0.0000%
Enrollee premiums (d)				
Enrollees, individually purchased insurance	$25,775,325,000	$25,775,554,000	$229,000	0.0009%
Outside Covered California	$9,551,761,000	$9,551,851,000	$90,000	0.0009%
Through Covered California	$16,223,564,000	$16,223,703,000	$139,000	0.0009%
Enrollees, group insurance	$21,828,135,000	$21,828,250,000	$115,000	0.0005%
Total premiums	$174,928,615,000	$174,929,323,000	$708,000	0.0004%

Source: California Health Benefits Review Program, 2026.
Notes: (a) In some cases, a union or other organization. Excludes CalPERS.
(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 49.0% are state retirees, state employees, or their dependents. About one in five (20.4%) of these enrollees has a pharmacy benefit not subject to DMHC.[24] 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 Medi-Cal beneficiaries enrolled in DMHC-regulated plans and 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.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care.

Enrollee Expenses for Benefit Users

AB 1843 would impact expenses for all enrollees by increasing premiums (discussed directly above) and by decreasing cost sharing by a total of $40,000 across all users of DAAs. Cost sharing on average decreases because of the reduction in utilization of services to treat clinical complications associated with untreated hepititis C and reductions of tests and services from the removal of prior authorization (Table 4); these services are covered under the medical benefit and may be subject to higher cost-sharing amounts than DAAs covered under the pharmacy benefit. Specifically:

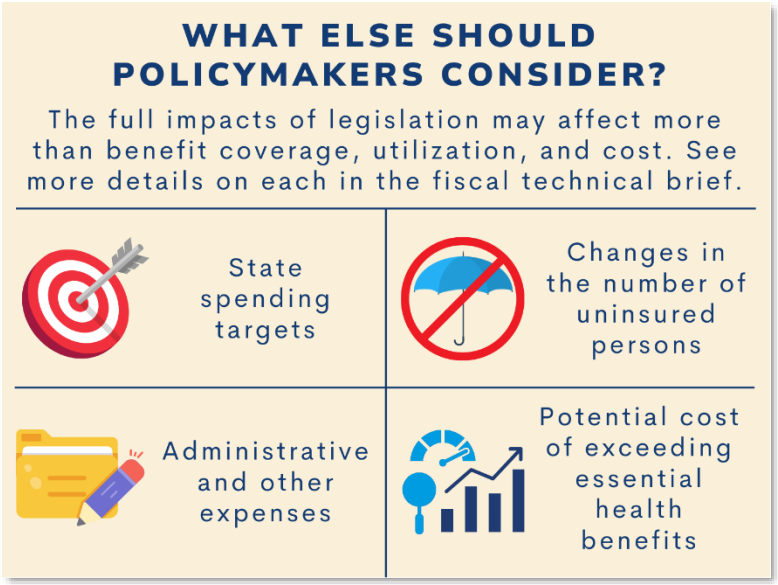
- For the 443 enrollees with coverage for DAAs without prior authorization requirements at baseline, average annual enrollee cost sharing would not change; however, their premiums would slightly increase because premiums for the entire risk pool would be estimated to increase as a result of AB 1843 (Table 4).
- For the 342 enrollees using DAAs at baseline and who have prior authorization requirements, average annual expenses would decrease as a result of lower cost sharing because they would no longer receive tests or services that were required as part of the prior authorization requirements.
- The 34 enrollees who would newly utilize DAAs because of the removal of prior authorization requirements would experience an average increase in cost sharing of $1,094, which is the average cost sharing for a course of treatment with DAAs; however, these enrollees would also avoid complications, tests, and visits due to receiving treatment for hepatitis C, and therefore most enrollees would experience an overall reduction in cost sharing compared with

[24] For more detail, see CHBRP's resource *Pharmacy Benefit Coverage in State-Regulated Health Insurance*.

baseline. The net change in cost sharing for these users can increase or decrease, depending on the average level of cost sharing for the DAAs and the average medical cost sharing. For example, enrollees in large-group plans and policies experience an average net increase in annual cost sharing because most of the enrollees have relatively high cost sharing for DAAs that is only partially offset by relatively low cost sharing for avoided complications. In contrast, enrollees in small-group plans and policies have an average net decrease in annual cost sharing because most of the enrollees have relatively low cost sharing for DAAs and relatively high cost sharing for services associated with avoided complications.

These values reflect averages, whereas individual enrollees' experiences would vary based on the specific medications utilized by the enrollee, as well as the specific plan's or policy's cost-sharing design — which may include a high deductible — and its utilization management protocols.[25,26] If an enrollee has not met their deductible, this could result in the enrollee paying the full unit cost. In contrast, if they have met their out-of-pocket maximum, this would result in the enrollee having no further cost sharing.

As shown in Table 5, enrollees not using DAAs either at baseline or postmandate would not experience a change in average enrollee cost sharing. The effect on their annual premiums would be a slight, with the increase ranging from $0.03 (large-group enrollees) to $0.09 (individual market enrollees). AB 1843–related changes in cost sharing for covered benefits (deductibles, copays, etc.) are related to the number of enrollees with health insurance that would be subject to AB 1843 expected to use the relevant tests, treatments, or services during the year after enactment (see Table 7 and Table 8). These changes would vary by market segment, except expenses for noncovered benefits are zero at baseline across all market segments and do not change postmandate.



See more information in CHBRP's Technical Brief on AB 1843, including what else policymakers should consider such as state spending targets, impacts to the number of uninsured in California, how lack of benefit coverage shifts costs to other payers, changes in public program enrollment, and administrative and other expenses.

Back to Table of Contents

[25] For most enrollees in most plans and policies regulated by DMHC or CDI, applicable copays and coinsurance for prescription medications is limited to $250, or $500 for enrollees in the "bronze plans" available from Covered California, the state's ACA marketplace (HSC §1342.73; INS §10123.1932). Cost sharing could be higher for an enrollee in a plan or policy that includes a deductible.
[26] For estimates of enrollees in plans and policies with deductibles, see CHBRP's resource *Deductibles in State-Regulated Health Insurance*.

Table 4. Impact of AB 1843 on Average User Expenses, 2027

	Large Group	Small Group	Individual	CalPERS	Medi-Cal
DAA users without baseline prior authorization requirements					
% of population with enrollee expenses impacted by AB 1843 (a)	0.00399%	0.00215%	0.00255%	0.00305%	N/A
Average annual enrollee expenses and premium impact for users (b)	$0.03	$0.09	$0.09	$0.06	N/A
DAA users with baseline prior authorization requirements					
% of population with enrollee expenses impacted by AB 1843 (a)	0.00185%	0.00369%	0.00391%	0.00295%	N/A
Average annual enrollee expenses and premium impact for users (b)	-$28.67	-$69.44	-$85.19	-$17.07	N/A
New users of DAAs postmandate					
% of population with enrollee expenses impacted by AB 1843 (a)	0.00019%	0.00037%	0.00039%	0.00030%	N/A
Average annual enrollee expenses and premium impact for users (b)	$644.36	-$894.61	-$679.64	-$245.45	N/A

Source: California Health Benefits Review Program, 2026.
Notes: (a) The percentages in this table are calculated from the population of 13,156,663 enrollees with a state-regulated pharmacy benefit.
(b) Average enrollee expense impact includes cost sharing (deductibles, copays, etc.) impact for covered benefits, out-of-pocket expense impact for noncovered benefits, and premium impact (employee portion only).
Key: DAAs = direct acting antivirals.

Table 5. Impact of AB 1843 on Average Non-User Enrollee Expenses, 2027

	Large Group	Small Group	Individual	CalPERS	Medi-Cal
% of population not using DAAs	99.994%	99.994%	99.993%	99.995%	N/A
Average annual premium impact for non-users (b)	$0.03	$0.09	$0.09	$0.05	N/A

Source: California Health Benefits Review Program, 2026.
Key: DAAs = direct acting antivirals.

AB 1843 Impacts: Public Health

The public health impact analysis includes estimated impacts in the short term (within 12 months of full implementation) and in the long term (beyond the first 12 months following full implementation). This section estimates the short-term impact[27] of AB 1843 on health outcomes, potential disparities, and financial burden. See *Long-Term Impacts* for discussion of premature death and economic loss.

Estimated Public Health Outcomes

Measurable health outcomes relevant to AB 1843 include SVR from DAA therapy (which represents the percentage of patients with cured HCV, defined as an undetectable viral load 12 weeks after treatment ends [SVR12]), as well as impacts on other non-liver diseases, symptoms, or conditions caused by the HCV infection that occur outside of the liver, and liver-related morbidity and mortality.

As presented in the *Overview* section, there is *very strong evidence* that DAAs consistently achieve high cure rates, with SVR12 exceeding 95%, the established standard for virologic cure. There is also *very strong evidence* that DAAs improve health outcomes, such as reducing the risk of liver cancer after SVR and lowering 1-year HCV recurrence. Additionally, achieving SVR with DAAs is associated with improvements in health-related quality of life and lower risk of chronic kidney disease/end-stage kidney disease, stroke, major adverse cardiac events, and neurocognitive disorders. DAA therapy can also lead to reduced hospitalizations, including reductions in liver-related hospital admissions for patients with cirrhosis. There is *some evidence* prior authorization or other utilization management policies for DAAs impact utilization of DAAs, and *not enough research* to determine whether prior authorization or other utilization management policies for DAAs impact subsequent health outcomes.

As presented in the *Benefit Coverage and Cost Impacts* section, the number of enrollees using DAA therapy for HCV infection would increase by 34 enrollees in the first year postmandate (from 785 enrollees to 819 enrollees). Newly treated enrollees would see an annual average decrease of $7,650 in avoided costs related to hepatitis C complications. Additionally, an estimated 924 pretreatment tests and services would be avoided among baseline users of DAA, as these would no longer be required under prior authorization requirements.

As discussed in the *Overview*, despite recommendations for universal HCV screening, studies have found delays in hepatitis C diagnosis and treatment initiation (Levesley et al., 2025; Moorman et al., 2015). The new simplified treatment algorithms and “test and treat” services may help identify enrollees with HCV infection earlier and initiate treatment in a more timely manner, increasing the percentage of people who clear infection and preventing disease complications.

Despite *very strong evidence* that DAAs are medically effective, CHBRP projects no measurable public health impact at the population level due to the small estimated increase in utilization after prior authorization is removed, given other barriers to HCV care. However, in the first year postmandate, AB 1843 would likely yield health and quality-of-life improvements for the 34 additional enrollees using DAAs, such as earlier achievement of virologic cure, reduced risk of liver cancer and other non-liver–related complications, and reduced hospitalizations. Enrollees avoiding pretreatment assessments no longer required under prior authorization would also experience quality-of-life improvements and would likely begin DAA therapy sooner.

Impact on Financial Burden

As presented in the *Benefit Coverage and Cost Impacts* section, CHRBP estimates that the pretreatment tests and services no longer required under prior authorization would result in an estimated average annual decrease of $346 in

[27] CHBRP defines short-term impacts as changes occurring within 12 months of full implementation of an enacted law.

related costs per treated enrollee with hepatitis C, and therefore would experience a decrease in annual cost sharing. Additionally, CHBRP estimates that newly treated enrollees with hepatitis C would see an average annual decrease of $7,650 in avoided costs related to hepatitis C complications and therefore would, on average, experience lower cost sharing postmandate. However, enrollees would still be required to pay an average of $1,094 DAA treatment, which may lead to some enrollees not obtaining treatment or delaying treatment because of cost.

Impact on Disparities[28]

Disparities and differences in new cases of hepatitis C and use of DAA treatment exist by age, race/ethnicity, gender, socioeconomic status, and geography. More information on disparities in hepatitis C can be found in the *Background* section in CHBRP's Technical Brief on AB 1843. Within the first 12 months postmandate, the impact of AB 1843 on disparities is unknown given the overall small estimated increase in utilization and because data are unavailable to estimate how expected changes in utilization of DAA treatment would vary by different groups of newly covered enrollees.

Back to Table of Contents

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

AB 1843 Impacts: Long-Term

In this section, CHBRP estimates the long-term impact of AB 1843, which CHBRP defines as impacts occurring beyond the first 12 months after legislation is fully implemented.[29] 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.

Long-Term Utilization and Cost Impacts

Utilization Impacts

The long-term utilization impacts include the following:

- The postmandate increase in utilization of DAAs by enrollees diagnosed with hepatitis C in Year 1 would likely continue in subsequent years because newly diagnosed individuals would not be subject to prior authorization requirements. This impact might increase over time as treating physicians become more aware of the prohibition on prior authorization requirements, and their treatment more closely aligns with the AASLD/IDSA guidelines. However, the magnitude and timing of this increase are uncertain.
- As a result, reduction in utilization of tests and services would likely continue in years following Year 1, including the following:
    - Reduced utilization of tests and services, specifically genotype testing, ultrasounds, and specialist visits. Again, this impact might increase over time as treating physicians become more aware of the prohibition on prior authorization requirements, and their treatment more closely aligns with the AASLD/IDSA guidelines. However, the magnitude and timing of this increase are uncertain.
    - Reduced utilization in services to treat hepatitis C–related clinical complications would continue as these may occur for up to 20 years after infection (WHO, 2025); however, the precise long-term impact is unknown.
- Furthermore, additional use of DAAs to treat hepatitis C will prevent transmission of the disease to others in years following Year 1, resulting in lower health care utilization for people who avoid infection because others were treated. The effect would likely be small because of the small number of additional enrollees who would be treated as a result of AB 1843, although the effect may grow over time should the share of enrollees with hepatitis C who use DAAs grow over time.

Cost Impacts

The long-term cost impacts would reflect the long-term utilization impacts discussed above. Increasing the number of enrollees with hepatitis C who are treated with DAAs would increase pharmacy benefit costs. However, these costs would likely be partially offset by the utilization offsets described above. The magnitude and timing of these costs, including cost offsets, are uncertain.

Long-Term Public Health Impacts

Some interventions in proposed mandates provide immediate measurable impacts (e.g., maternity service coverage or acute care treatments), whereas other interventions may take years to make a measurable impact (e.g., coverage for tobacco cessation or vaccinations). When possible, CHBRP estimates the long-term effects (beyond 12 months

[29] Full-scale implementation typically requires a “ramp up” period which may include educating enrollees, providers, and insurance carriers on the new benefits or coverage; updating procedures and policies; and increasing provider capacity for marginal utilization resulting from AB 1843. Furthermore, some policies may have staggered implementation or longer-term changes in utilization. The short-term, incremental impact estimated by CHBRP assumes there is no “ramp up” period and represent ongoing annual costs at full-scale implementation of AB 1843, including potential short-term offsets. CHBRP further assumes that state and industry policies and provider and patient behaviors would remain constant throughout the time period it takes for the full impact of the bill to be realized.

postmandate) to the public's health that would be attributable to the mandate, including impacts disparities, premature death, and economic loss.

In the case of AB 1843, CHBRP estimates the increased utilization of DAA treatments by individuals diagnosed with hepatitis C would likely continue in the long term. Long-term public health impacts — including lower risk of HCV-associated liver and non-liver–related conditions (e.g., cirrhosis, end-stage liver disease, chronic kidney disease/end-stage kidney disease, stroke, major adverse cardiac events, and neurocognitive disorders), avoided hospitalizations, and improved quality of life — are likely to continue beyond the first year postmandate. It is unknown whether AB 1843 would change the social drivers of unequal access to DAA treatment, including stigma around HCV testing and inadequate access to HCV testing and linkage to hepatitis C care. Recent studies have found that the majority of DAA treatment is still prescribed by specialists (gastroenterologists, infectious disease specialists) (Majethia et al., 2022); however, studies have found that HCV treatment can be managed by primary care providers (Wang et al., 2022). It is possible that increased uptake of the 2025 AASLD/IDSA test-to-treat algorithm in the long term will increase access to DAA treatment in more health care settings as more nonspecialists prescribe DAA therapy for patients with HCV infection.

Impacts on Premature Death and Economic Loss

Premature death

Premature death, measured by years of potential life lost (YPLL), is often defined as death occurring before the age of 75 years (NCI, 2019).[30] CDC surveillance data shows that deaths due to hepatitis C were higher among older adults (aged 55-74 years) than other age groups in 2023, accounting for 75% of all hepatitis C deaths (CDC, 2025). The mortality rate among adults aged 55 to 64 and 65 to 74 were 8.84 and 13.88 per 100,000 population, whereas the mortality rate among adults younger than age 55 ranged from 0.11 to 2.30 per 100,000 population, and the mortality rate among adults aged 75 years or older was 5.23 per 100,000 (CDC, 2025). This data suggests that individuals with hepatitis C are at risk of premature death.

Postmandate, enrollees with hepatitis C who have improved access to DAA treatment under AB 1843 may avoid premature death associated with hepatitis C compared to enrollees who are not treated.

Economic loss

Economic loss associated with disease is generally presented in the literature as an estimation of the value of the YPLL in dollar amounts (i.e., valuation of a population's lost years of work over a lifetime). In addition, morbidity associated with the disease or condition of interest can also result in lost productivity by causing a worker to miss days of work due to illness or acting as a caregiver for someone else who is ill.

One study including 339,456 employees (including 1,664 employees with HCV infection) found that employees with HCV infection experienced significantly more sick leave, short-term disability, and long-term disability over the course of one year, including 4.15 more days absent compared to employees without HCV (Su et al., 2010). Another study including 3,052 patients with HCV found that patients who were treated (including with DAAs) had a lower risk of work loss (leave of absence, short- or long-term disability, early retirement) compared to untreated patients over a 4-year follow-up period (resulting in a productivity value of $21,429 at 4 years) (Sulkowski et al., 2020). Taken together, these findings suggest that individuals with hepatitis C may experience more lost productivity compared to those without hepatitis C, but treatment can mitigate some of this lost productivity and economic loss.

Postmandate, enrollees with hepatitis C who have improved access to DAA treatment under AB 1843 may avoid lost productivity and economic loss compared to enrollees who are not treated.

Back to Table of Contents

[30] For more information about CHBRP's public health methodology, see CHBRP's Public Health Impact Analysis and Research Approach.

Appendix. Impacts of AB 1843 on Benefit Coverage and Expenditures, 2027

Table 6. Impacts of AB 1843 on Benefit Coverage, 2027

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Total enrollees with health insurance subject to state benefit mandates (a)	22,842,000	22,842,000	0	0.00%
Number of enrollees with health insurance subject to AB 1843 but **without a pharmacy benefit regulated** by DMHC or CDI (b)	9,685,337	9,685,337	0	0.00%
Number of enrollees **with a pharmacy benefit regulated** by DMHC or CDI and coverage for at least one DAA for hepatitis C	13,156,663	13,156,663	0	0.00%
Number of enrollees with a pharmacy benefit regulated by DMHC or CDI and fully compliant coverage for mandated benefit (i.e., without prior authorization for DAAs for hepatitis C)	7,463,428	13,156,663	5,693,235	76.28%
Percentage of enrollees with a pharmacy benefit regulated by DMHC or CDI and fully compliant coverage for mandated benefit (i.e., without prior authorization for DAAs for hepatitis C)	57%	100%	43%	76.28%

Source: California Health Benefits Review Program, 2026.
Notes: (a) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.[31]
(b) Considered compliant at baseline, but if the pharmacy benefit is added or would become subject to the Health and Safety Code, then it would need to comply.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; DAA = direct-acting antiviral; DMHC = Department of Managed Health Care.

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

Table 7. Baseline Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2027

	DMHC-Regulated						CDI-Regulated			
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Policies (by Market) (a)			
	Large Group	*Small Group*	*Individual*	*CalPERS (b)*	*Medi-Cal (c)*		*Large Group*	*Small Group*	*Individual*	Total
					Under 65	*65+*				
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	7,929,000	2,097,000	2,444,000	931,000	8,078,000	965,000	315,000	42,000	41,000	22,842,000
Total enrollees in plans/policies subject to AB 1843	7,929,000	2,097,000	2,444,000	931,000	0 (update)	0 (update)	315,000	42,000	41,000	22,842,000
Premiums										
Average portion of premium paid by employer (e)	$619.33	$539.05	$0.00	$770.84	$367.89	$632.17	$780.34	$573.31	$0.00	$127,325,155,000
Average portion of premium paid by enrollee	$134.02	$263.52	$864.90	$145.41	$0.00	$0.00	$184.88	$242.16	$832.16	$47,603,460,000
Total premium	**$753.35**	**$802.56**	**$864.90**	**$916.25**	**$367.89**	**$632.17**	**$965.22**	**$815.47**	**$832.16**	**$174,928,616,000**
Enrollee expenses										
Cost sharing for covered benefits (deductibles, copays, etc.)	$56.38	$184.07	$271.63	$70.59	$0.00	$0.00	$126.72	$213.52	$192.93	$19,432,815,000
Expenses for noncovered benefits (f)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0
Total expenditures	**$809.72**	**$986.63**	**$1,136.53**	**$986.84**	**$367.89**	**$632.17**	**$1,091.94**	**$1,029.00**	**$1,025.09**	**$194,361,431,000**

Source: California Health Benefits Review Program, 2026.
Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).
(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.6% are state retirees, state employees, or their dependents. About one in five of these enrollees has a pharmacy benefit not subject to DMHC.[32] 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 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.[33]
(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.

[32] For more detail, see CHBRP's resource *Pharmacy Benefit Coverage in State-Regulated Health Insurance.*
[33] For more detail, see CHBRP's resource *Sources of Health Insurance in California*.

Table 8. Postmandate Change in Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2027

	DMHC-Regulated						CDI-Regulated			
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Policies (by Market) (a)			
	Large Group	*Small Group*	*Individual*	*CalPERS (b)*	*Medi-Cal (c)*		*Large Group*	*Small Group*	*Individual*	Total
					Under 65	*65+*				
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	7,929,000	2,097,000	2,444,000	931,000	8,078,000	965,000	315,000	42,000	41,000	22,842,000
Total enrollees in plans/policies subject to AB 1843	7,929,000	2,097,000	2,444,000	931,000	8,078,000	965,000	315,000	42,000	41,000	22,842,000
Premiums										
Average portion of premium paid by employer (e)	$0.0017	$0.0052	$0.0000	$0.0034	$0.0000	$0.0000	$0.0083	$0.0094	$0.0000	$364,000
Average portion of premium paid by enrollee	$0.0004	$0.0026	$0.0076	$0.0007	$0.0000	$0.0000	$0.0020	$0.0040	$0.0125	$344,000
Total premium	$0.0020	$0.0078	$0.0076	$0.0041	$0.0000	$0.0000	$0.0103	$0.0134	$0.0125	**$708,000**
Enrollee expenses										
Cost sharing for covered benefits (deductibles, copays, etc.)	$0.0000	-$0.0006	-$0.0007	-$0.0001	$0.0000	$0.0000	$0.0003	-$0.0008	$0.0017	-$40,000
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	$0.0020	$0.0072	$0.0069	$0.0004	$0.0000	$0.0000	$0.0106	$0.0126	$0.0142	**$668,000**
Percent change										
Premiums	0.0003%	0.0010%	0.0009%	0.0004%	0.0000%	0.0000%	0.0011%	0.0016%	0.0015%	0.0004%
Total expenditures	0.0002%	0.0007%	0.0006%	0.0004%	0.0000%	0.0000%	0.0010%	0.0012%	0.0014%	0.0003%

Source: California Health Benefits Review Program, 2026.
Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).
(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.6% are state retirees, state employees, or their dependents. About one in five of these enrollees has a pharmacy benefit not subject to DMHC.[34] 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 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.[35]
(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.

Back to Table of Contents

[34] For more detail, see CHBRP's resource *Pharmacy Benefit Coverage in State-Regulated Health Insurance*.
[35] For more detail, see CHBRP's resource *Sources of Health Insurance in California*.

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CHBRP is an independent program administered and housed by the University of California, Berkeley, under the Office of the Vice Chancellor for Research. A group of faculty, researchers, and staff complete the analysis that informs CHBRP reports. The CHBRP **Faculty Task Force** comprises rotating senior faculty from University of California (UC) campuses. In addition to these representatives, there are other ongoing researchers and analysts who are **Task Force Contributors** to CHBRP from UC that conduct much of the analysis. The **CHBRP staff** works with Task Force members in preparing parts of the analysis, and manages external communications, including those with the California Legislature. As required by CHBRP's authorizing legislation, UC contracts with an independent actuarial firm, **Milliman, Inc.**, to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit. The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. Information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications, are available at chbrp.org.

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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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About CHBRP

The California Health Benefits Review Program (CHBRP) was established in 2002. CHBRP's mission is to inform and support policymaking in California through the creation of impartial, evidence-based resources. 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. CHBRP is dedicated to providing academic rigor on a Legislature's timeline.

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. An independent actuarial firm 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.

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CHBRP analyzes bills in the current environment given current law and regulations at both the state and federal levels. Each analysis assumes that policy frameworks and stakeholder behaviors remain constant, unless otherwise noted. All estimates are based on current data and do not take into consideration any future or potential changes to factors that may influence the impacts of the legislation, unless otherwise specifically mentioned. Differences between CHBRP's estimated impacts and actual impacts of legislation will depend on alignment with the assumptions used in this analysis, the timeline of implementation, and the final language of the legislation, should it be signed into law. Since actual experience is unlikely to match assumptions perfectly, final impacts will differ from those projected in this analysis.

This analysis is based on existing literature and public sources identified through systematic search methods. This evidence informs the California Legislature about potential impacts of proposed health benefit legislation and does not constitute a policy recommendation from CHBRP.

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