A REPORT TO THE 2025–2026 CALIFORNIA LEGISLATURE

Bill Analysis Report: California Assembly Bill 1906 Cervical Cancer Screening

APRIL 20, 2026

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

chbrp.org

KEY FINDINGS

Analysis of California Assembly Bill 1906 Cervical Cancer Screening

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

CHBRP

Summary

The version of California Assembly Bill (AB) 1906 analyzed by the California Health Benefits Review Program (CHBRP) would require coverage without cost sharing for annual home test kits for cervical cancer screening as referred by a health care provider.

If enacted, AB 1906 would apply to the health insurance of approximately 22,842,000 enrollees (60% of all Californians).

Background

Cervical cancer develops in the cells of the cervix from persistent infection with high-risk human papillomavirus (hrHPV). There are three primary methods for screening for cervical cancer: human papillomavirus (HPV) testing; cytology or Pap testing; and the HPV/Pap co-test. As currently available home test kits are designed to detect HPV rather than cervical cancer cells, CHBRP's analysis of AB 1906 primarily focuses on hrHPV testing

Historically, samples for both the HPV test and Pap test have been collected from the cervix during a pelvic exam in a clinical setting. More recently, technology has developed to allow for HPV testing to be performed using self-collected samples, where a speculum or pelvic exam is not required. This can occur at home or in a health clinic or office, depending on the test used.

Benefit Coverage

At baseline, 40% of enrollees in state-regulated health insurance have coverage without cost sharing for home test kits for cervical cancer screening. Postmandate, 100% of enrollees in state-regulated health insurance would have coverage compliant with AB 1906.

AB 1906 would not exceed essential health benefits (EHBs).

Medical Effectiveness

The Teal Wand is currently the only U.S. Food and Drug Administration (FDA)-authorized home test kit for cervical cancer screening available for use (approved May 2025), demonstrating 95% agreement with clinician samples and strong sensitivity for high-grade dysplasia detection. The scientific consensus and pooled data, including the information reviewed for the United States Preventive Services Task Force (USPSTF) guidelines that included studies comparing self-collected specimens, both in the home and in clinical settings, indicate *very strong* evidence that properly collected self-samples provide accurate, stable, and clinically valid HPV detection suitable for future widespread home-based screening.

Cost Impacts

Postmandate, CHBRP estimates that 6,798 enrollees would use cervical cancer screening home test kits, an increase of 5,753 new users of this modality as a result of AB 1906. For enrollees with baseline coverage without cost sharing, this increase in utilization is attributable to increased awareness. For enrollees without $0 baseline coverage, this increase in utilization is attributed to the removal of cost sharing and increased convenience of the home test option.

AB 1906 would increase premiums by $1,580,000 in the first year.

Public Health Impacts

CHBRP concludes that passage of AB 1906 would have no measurable short-term public health impact.

Long-Term Impacts

Over time, utilization of home test kits for cervical cancer screening is expected to increase as provider familiarity grows, additional manufacturers enter the market, health plan outreach about the home test option expands, self-collection technology advances, and home kits become more integrated into routine clinical workflows.

Over time, home test kits may address disparities in screening rates by reducing certain barriers to screening, including structural, individual, and cultural barriers.

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Acronyms and Terminology

Acronyms

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

DHCS – Department of Health Care Services

DMHC – Department of Managed Health Care

EHBs – essential health benefits

FDA – U.S. Food and Drug Administration

HPV – human papillomavirus

hrHPV – high-risk human papillomavirus

HRSA – Health Resources and Services Administration

SB – Senate Bill

SDOH – social drivers of health

USPSTF – United States Preventive Services Task Force

WPSI – Women's Preventive Services Initiative

YPLL – years of potential life lost

Terminology

CHBRP uses the following terminology for this analysis:

- **Cervical cytology (also known as a Pap test)**: a type of screening test that checks cervical cells for abnormalities caused by HPV that may progress to cervical cancer, such as precancerous cells and cancer cells. A Pap test may also find other noncancerous conditions, such as infection or inflammation.
- **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]).
- **Dysplasia:** a change that causes abnormal cells called precancers to appear in the cervical tissue. These abnormal cells can become cancerous if they are not destroyed or removed. Although some HPV infections can resolve on their own, persistent infection with hrHPV can cause cells of the cervix to go through dysplasia.
- **Home test kit**: a type of self-collection screening test that can be used in the home or other private space.
- **HPV/Pap co-test**: a screening test that combines the HPV and Pap tests to detect high-risk HPV infection as well as cellular abnormalities.
- **HPV testing**: a type of screening test that checks cells for infection with high-risk HPV (hrHPV) types associated with cervical cancer.
- **Self-collected (or patient-collected) HPV test**: Self-collected HPV tests, also commonly referred to as patient-collected HPV tests, allow a patient to swab their own vagina in a private setting to screen for hrHPV. Some of the existing tests using this technology must be used in a clinical setting, while others can be used at home. Tests that are U.S. Food and Drug Administration (FDA)-approved for patient collection only in a health care facility under the supervision of a health care provider are not in scope for AB 1906. CHBRP uses patient-collected and self-collected terminology interchangeably throughout this analysis to align with terminology used by sources.

[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.

Overview: AB 1906 and Cervical Cancer Screening

On February 20, 2026, the California Assembly Committee on Health requested that the California Health Benefits Review Program (CHBRP)[2] conduct an evidence-based assessment of the medical, financial, and public health impacts of Assembly Bill (AB) 1906, Cervical Cancer Screening, as introduced on February 12, 2026.

Bill Language of AB 1906

AB 1906 would require coverage without cost sharing for annual home test kits for cervical cancer screening as referred by a health care provider. See the full text of AB 1906 in the Technical Brief on AB 1906.

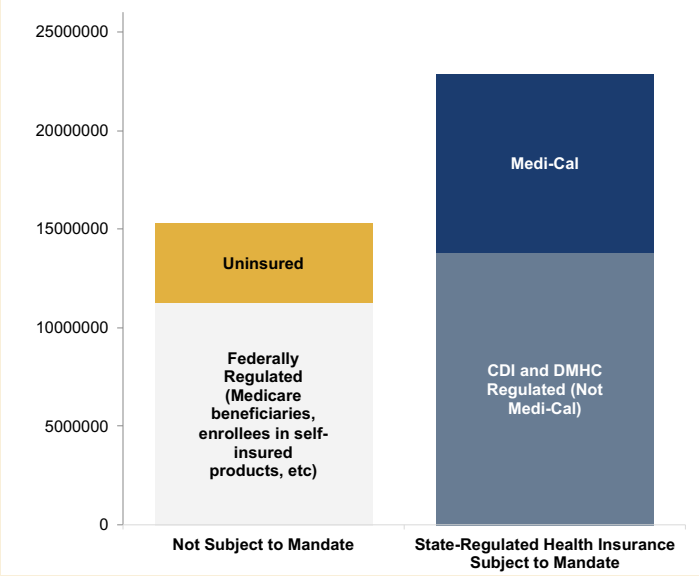
If enacted, AB 1906 would apply to the health insurance of approximately 22,842,000 enrollees (60% of all Californians) (see Figure 1).

AB 1906 includes: Enrollees in commercial or CalPERS health insurance regulated by the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI), as well as Medi-Cal beneficiaries enrolled in DMHC-regulated plans and County Organized Health Services (COHS) plans.

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. [3]

CHBRP provides an overview of common cost-sharing practices that are addressed by AB 1906 in its explainer *What Is Cost Sharing?*.

Figure 1. Health Insurance in CA and AB 1906



Source: California Health Benefits Review Program, 2026.
Note: CHBRP generally assumes alignment of Medi-Cal Managed Care plan benefits, with limited exceptions.[1]
Key: CDI = California Department of Insurance; DMHC = Department of Managed Health Care.

What Is Cervical Cancer Screening?

Cervical cancer is a type of cancer that develops in the cells of the cervix, the lower, narrow end of the uterus. Persistent infection with high-risk human papillomavirus (hrHPV) can cause cells of the cervix to go through dysplasia, a change that causes abnormal cells called precancers to appear in the cervical tissue. These abnormal cells can become cancerous if they are not destroyed or removed (CDC, 2024; NCI, 2023). Approximately 99.7% of cervical cancer cases are associated with persistent infection with hrHPV types (Okunade, 2020). Among hrHPV types, HPV 16 and HPV 18 are responsible for most HPV-related cancers (NCI, 2025c). Additionally, the American Cancer Society (ACS) estimates that approximately 1,490 new cervical cancer cases will be diagnosed in California in 2026, with 400 related deaths (ACS, 2026).

HPV is the most common sexually transmitted infection in the United States, with an estimated 13 million new cases each year, and will infect approximately 85% of the population at some point in their lifetime (CDC, 2021b; 2021c). Cervical cancer remains the most common HPV-related cancer. Although HPV vaccination is anticipated to lead to a 90%

[2] See CHBRP's authorizing statute.
[3] For more detail, see CHBRP's resource, *Sources of Health Insurance in California*.

reduction in cervical cancer among those vaccinated during adolescence, studies have shown that the full benefits of vaccination do not occur until the vaccinated population reaches mid- to late life (Lei et al., 2020; Mix et al., 2021). As a result, cervical cancer screening remains an important preventative measure against cervical cancer. Cervical cancer screening detects precancerous changes in cervical cells so that treatment can prevent the development of invasive cancer (NCI, 2025a).

There are three primary methods for screening for cervical cancer:

- **HPV testing**, which checks cells for infection with hrHPV types that have been associated with cervical cancer.
- **Cytology or Pap testing**, where cervical cells are checked for abnormalities caused by HPV that may indicate precancerous or cancerous cells on the cervix. A Pap test may also find other noncancerous conditions, such as infection or inflammation. However, Pap testing does not detect hrHPV itself, only cellular abnormalities as a result of the infection.
- **The HPV/Pap co-test** combines both methods to detect hrHPV infection as well as cellular abnormalities (ACS, 2025a).

As currently available home test kits are designed to detect HPV rather than cervical cancer cells, CHBRP's analysis of AB 1906 primarily focuses on hrHPV testing. Historically, samples for both the HPV test and Pap test have been collected from the cervix during a pelvic exam by a health care provider in a clinical setting. More recently, technology has developed to allow for HPV testing to be performed using self-collected samples, where a speculum or pelvic exam by a health care provider is not required. There are two ways in which self-collection can occur:

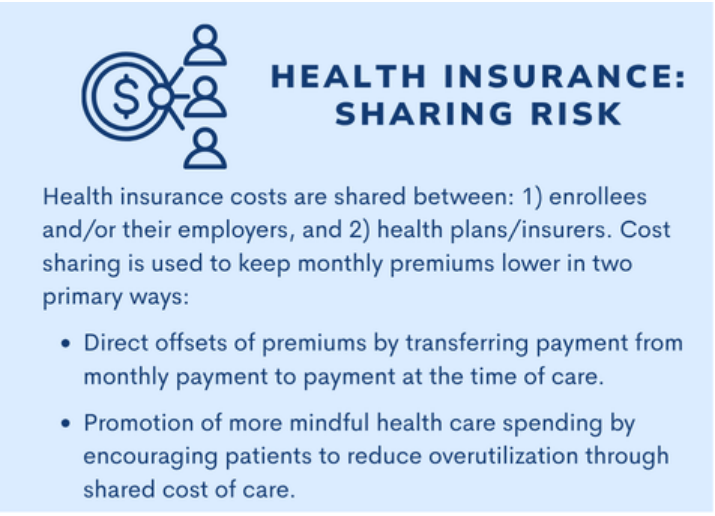
- **Self-collection in a health clinic or office:** tests that are approved by the FDA to self-collect specimens in a health care facility under the supervision of a health care provider (ACS, 2025b). In May 2024, two tests using self-collection of vaginal samples for HPV testing were granted FDA approval for such use (NCI, 2024). A third in-clinic self-collection test received FDA approval in September 2025 (Abbott, 2025).
- **Self-collection at home:** tests that are approved, authorized, or cleared by the FDA to self-collect specimens in the home or a similarly private setting. Home test kits are provided by a health care provider and mailed back by the user to a lab for processing (ACS, 2025b). In May 2025, the FDA authorized the first device for self-collection of cervical specimens in the home. This test – the Teal Wand – is the only one of its kind with FDA authorization on the market as of April 2026. On April 8, 2026, the FDA cleared the Becton, Dickinson (BD) Onclarity HPV Assay for at-home use (Reuters, 2026).[4] As of the time this report was published, the BD Onclarity HPV Assay was not available for use.

Tests that are FDA-approved for patient collection only in a health care facility under the supervision of a health care provider are not in scope for AB 1906. Although the Teal Wand is currently the only FDA-authorized home test kit for cervical cancer screening available for use in the United States, the market is evolving rapidly. For more information, see the *Long-Term Impacts* section.

The U.S. Preventive Services Task Force (USPSTF) recommends that women aged 21 to 29 years screen for cervical cancer every 3 years with cervical cytology alone. For women aged 30 to 65 years, USPSTF recommends screening every 3 years with cytology alone, hrHPV testing alone every 5 years, or co-testing every 5 years (USPSTF, 2018). Additionally, in January 2026, the Health Resources and Services Administration (HRSA)-supported Women's Preventive Services Guidelines for cervical cancer screening were updated in accordance with the Women's Preventive Services Initiative (WPSI) recommendations.[5] For women aged 21 to 29 years, HRSA recommends cervical cancer screening with cytology every 3 years. For women aged 30 to 65 years, the preferred method of screening is HPV testing every 5 years. However, co-testing every 5 years or cytology alone every 3 years may be used. HRSA guidelines also state that patient-

[4] The BD Onclarity HPV Assay received FDA clearance for at-home use on April 8, 2026. As of publication date, it is not currently available for patient use. Given this timing, it was not incorporated into CHBRP's analysis of AB 1906.
[5] The HRSA-supported health plan coverage guidelines for women's preventive services adopt certain recommendations from the Women's Preventive Services Initiative (WPSI). WPSI provides additional implementation considerations that are separate from clinical recommendations and not part of the guidelines as accepted by the Administrator.

collected hrHPV testing is an appropriate option and should be offered to average-risk women in this age group (HRSA, 2025). Average risk is defined as those who do not have a previous diagnosis of cervical cancer or high-grade precancer, have no recent abnormal results, are not immunocompromised, and have no exposure to diethylstilbestrol[6] in utero (CDC, 2021a). Approximately 84% of women aged 21 to 65 years in California have received screening in accordance with USPSTF guidelines (CDPH, 2023).



Disparities in Cervical Cancer Screening

Screening participation varies by demographic factors. Younger women (ages 21 to 29 years), those with lower incomes, those without health insurance, and those without a regular health care provider are less likely to meet screening recommendations. Asian and Pacific Islander women also reported lower adherence to screening compared to other racial and ethnic groups (CDPH, 2023).

Home test kits may address screening barriers for the above-mentioned disparate populations by reducing certain barriers to screening, such as structural (e.g., wait times, provider availability), individual (e.g., health literacy, language, perceived risk), and cultural barriers (e.g., stigma, privacy). For an in-depth look at clinical guidance, existing disparities, and barriers to access to care for cervical cancer screening, see the *Background on cervical cancer* section in CHBRP's Technical Brief on AB 1906.

What Is the Teal Wand?

The only FDA-authorized home test kit for cervical cancer screening currently on the market (and thus the only one currently subject to AB 1906) is the Teal Wand HPV self-collection device. The Teal Wand is a single-use device designed for patients to self-collect vaginal specimens for hrHPV testing. During use, the patient inserts the device into the vaginal canal and rotates a dial on the handle, which deploys petal-like components that function as a mini-speculum, to expose the sponge and gently collect cells (FDA, 2025).

The Teal Wand can be requested online through the Teal Health website; ordering the kit requires attending a virtual visit with a Teal provider to review the patient's screening history and discuss the at-home screening steps. Currently, only a Teal provider can prescribe this device, and patients must access the home test kit through the Teal website (Teal Health, 2026). Because this step must currently be completed through Teal Health, at present there is no established mechanism for non-Teal providers to prescribe this device. As such, access relies primarily on patient self-referral; non-Teal providers may recommend their patients order the Teal Wand through Teal Health. Following the Teal provider consultation, a self-collection home test kit is mailed to the patient, who can collect the sample at home or in any private space and return it via mail to a Teal laboratory for testing. Virtual consultation to discuss follow-up care is available through Teal Health. The telehealth-only prescribing model for the Teal Wand has the potential to introduce additional access barriers for people with limited access to digital infrastructure or with insufficient technical capabilities.

Although AB 1906 applies to Medi-Cal Managed Care plans, Teal Health currently states that they cannot service Medi-Cal beneficiaries, even as self-pay patients (Teal Health, 2026). It is unknown at this time whether future home test kits for cervical cancer screening will service Medi-Cal beneficiaries.

[6] Diethylstilbestrol is a synthetic estrogen (female hormone) that was used to prevent miscarriage, premature labor, and related complications of pregnancy between 1940 and 1971. Research has linked exposure to DES in utero (to babies during pregnancy) to elevated risk of clear cell adenocarcinoma of the cervix and other cancers. Therefore, persons exposed to DES in utero are considered high risk for cervical cancers (NCI, 2025b).

How Effective Are FDA-Approved Home Test Kits for Cervical Cancer Screening?

CHBRP's medical literature review focused on determining the effectiveness of FDA-approved home test kits and other tests that use similar self-collection technology for cervical cancer screening through the detection of HPV.

Measurable health outcomes relevant to AB 1906 include equivalency or noninferiority of self-collected specimen samples collected outside of the clinical environment versus clinician-collected specimen samples for the purposes of screening and testing for cervical cancer via the detection of HPV.

CHBRP uses the terms and scale shown to the right to characterize the body of evidence regarding an outcome (Figure 2). See the *Medical Effectiveness Review* section of CHBRP's Technical Brief on AB 1906 for definitions of each term.

Figure 2. Medical Effectiveness of Home Test Kits for Cervical Cancer Screening

Current evidence shows that self-collected samples for HPV testing are highly effective for cervical cancer screening and perform comparably to clinician-collected samples when polymerase chain reaction (PCR)-based assays are used. The Teal Wand is currently the only FDA-authorized at-home collection device available for use (approved May 2025), demonstrating 95% agreement with clinician samples and strong sensitivity for high-grade dysplasia detection, though its pivotal trial occurred in a simulated home environment. Broader research, including the National Cancer Institute (NCI) SHIP (Self-sampling for HPV testing to Improve Cervical Cancer Prevention) Trial, and market expansion with the recently FDA-cleared BD Onclarity HPV Assay for at-home use, points to expanded at-home screening options in the very near future.

In summary, the scientific consensus and pooled data indicate *very strong*[7] evidence that, when instructions are properly followed, self-samples provide accurate, stable, and clinically valid HPV detection suitable for future widespread home-based screening. Currently, the Teal Wand is the only FDA-authorized home test kit for cervical cancer screening available for use, with at least one additional market entrant as of April 2026.

Policy Context

Preventive Services

Both the California Preventive Services Mandate and the Federal Preventive Services Mandate require coverage of certain preventive services without cost sharing for enrollees in nongrandfathered plans and policies following four sets of Federal recommendations.[8,9] Plans are required to provide such coverage within 12 months of the recommendation's publication. On January 5, 2026, the HRSA-supported health plan coverage guidelines for women's preventive services[10] updated its recommendation for cervical cancer screening to include that patient-collected hrHPV testing is an appropriate method and should be offered as an option for cervical cancer screening in women aged 30 to 65 years at average risk (HRSA, 2025). As such, impacted plans will be required to cover some form of patient-collected hrHPV tests without cost sharing by January 2027. However, as home test kits for cervical cancer screening are only one form of patient-collected testing, impacted plans may not necessarily cover them without cost sharing as a result of this HRSA recommendation. Some patient-collected tests are performed in a clinical setting, and plans may choose to cover this form of testing without

[7] *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.
[8] HSC 1367.002; INS 10112.2.
[9] More information about the state and federal requirements to cover specified preventive services is included in CHBRP's resource, *Federal Recommendations and the California and Federal Preventive Services Benefit Mandates*.
[10] The HRSA-supported health plan coverage guidelines for women's preventive services adopt certain recommendations from the Women's Preventive Services Initiative (WPSI). WPSI provides additional implementation considerations that are separate from clinical recommendations and not part of the guidelines as accepted by the Administrator.

cost sharing instead. For more information on how CHBRP incorporated this recommendation into its analysis of AB 1906, see the *Cost-Related Assumptions* section below.

As of April 2026, the USPSTF has published a draft recommendation for patient-collected hrHPV testing and sought public comment.

Additionally, in September 2025, Governor Newsom signed Assembly Bill 144, which requires nongrandfathered state-regulated health plans in California to cover preventive care services recommended by the federal government as of January 1, 2025, or recommended by the California Department of Public Health (CDPH), without cost sharing.[11] As of April 2026, CDPH has not published a recommendation for patient-collected hrHPV tests.

For additional details on the in-clinic cervical cancer screenings covered without cost sharing by these mandates, see the *Policy Framework* section of CHBRP's Technical Brief on AB 1906.

Existing State Law and Regulations

Cervical cancer screening coverage in California

Existing California law requires that commercial health plans and policies cover annual cervical cancer screening tests, including the Pap test, HPV screening tests approved by the FDA, and the option of any cervical cancer screening test approved by the FDA, upon the referral of the patient's health care provider. This statute does not prevent application of a deductible or copayment provisions on an existing plan contract.[12] Existing law requires coverage for Medi-Cal beneficiaries for annual cervical cancer tests for screening or diagnostic purposes, upon the referral of a patient's physician, to the extent required or permitted by federal law.[13]

Coverage of home test kits for sexually transmitted diseases in California

In 2021, Governor Newsom signed Senate Bill (SB) 306, requiring coverage of home test kits for sexually transmitted diseases (STDs), including laboratory costs of processing the kit, that are deemed medically necessary or appropriate and ordered directly by a clinician or furnished through a standing order for patient use based on clinical guidelines and individual patient needs. Statute requires coverage of all home test kits recommended by the CDC guidelines or USPSTF that has been CLIA-waived, FDA-cleared or -approved, or developed by a laboratory in accordance with established regulations and quality standards, to allow individuals to self-collect specimens for STDs, including HPV, remotely at a location outside of a clinical setting.[14]

Essential Health Benefits and the Affordable Care Act

Because cervical cancer screening home test kits fall within the essential health benefit (EHB) category of preventive services and screenings, AB 1906 would not exceed the current definition of EHBs in California. For more details, see the *Policy Framework* section of CHBRP's Technical Brief on AB 1906.

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[11] HSC Section 120164.
[12] HSC 1367.66, INS 10123.18.
[13] WIC 14132.17.
[14] HSC 1367.34, INS 10123.208, WIC 14132.

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 1906, unless otherwise specifically mentioned.

Language Interpretation

CHBRP made the following assumptions based on the language of AB 1906:

- AB 1906 does not specify a relevant population by age, risk level, or gender, nor does it restrict the coverage of mandated services to clinical guidelines. CHBRP assumes that the people who will be prescribed home test kits for cervical cancer screening are women of average risk of cervical cancer aged 30 to 65 years, as this is the population for which clinical guidelines commonly recommend hrHPV testing.
- AB 1906 requires referral from a health care provider for coverage without cost sharing for an annual home test kit for cervical cancer screening. Such a referral can be provided by any health care provider as defined in the California Insurance Code section 10133.65(h)(1).[15] The Teal Wand can currently be ordered only through Teal Health, and patients are required to attend a telehealth appointment with a Teal provider before using the home test kit. Given the breadth of definition of a health care provider in existing state law, CHBRP assumes that this interaction with a Teal provider constitutes a referral.
- Medical products that are FDA-authorized are often made available via an emergency use authorization during a public health emergency. An emergency use authorization allows these products to be used during a public health emergency without full FDA approval, but they must meet eligibility criteria and provide information in support of their safety and efficacy. While the FDA approval designation is more rigorous than FDA authorization, the latter is a pathway frequently utilized by the current FDA to grant access to medical products outside of a public health emergency. Given this nuance, CHBRP has assumed a broad interpretation of being "approved by the FDA" to include devices classified as FDA-authorized or FDA-approved.

Cost-Related Assumptions

This analysis reports the estimated incremental impact of full-scale implementation of AB 1906 on benefit coverage, utilization, and cost for a single year.[16] Full-scale implementation typically requires a "ramp up" period which may include educating enrollees, providers, and health plans and policies on the new benefits or coverage; updating procedures and policies; and increasing provider capacity for marginal utilization resulting from AB 1906. Furthermore, some policies may have staggered 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 1906. 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.[17] For a discussion of long-term impacts of AB 1906, see the *Long-Term Impacts* section.

[15] "Health care provider" is defined as any professional person, medical group, independent practice association, organization, health facility, or other person or institution licensed or authorized by the state to deliver or furnish health care services. INS 10133.65(h)(1).
[16] 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 1 year even if changes in coverage, utilization offsets, and costs may be realized in more than 1 year.
[17] 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.

Approach and Assumptions on Baseline Coverage and Utilization

- In January 2026, the HRSA-supported health plan coverage guidelines for women's preventive services recommendation for cervical cancer screening was updated to add that patient-collected hrHPV testing is an appropriate method and should be offered as an option for cervical cancer screening in women aged 30 to 65 years at average risk. CHBRP's interpretation of this recommendation is that it can reasonably apply to either in-clinic or home test kits that use self-collection sampling. This means that health plans and policies have the option to begin to cover either home test kits or in-clinic self-collected tests without cost sharing in January 2027 per the federal Preventive Services Act. Plans could also choose to cover both options without cost sharing but are not required to do so. Given the longer time on the market of in-clinic self-collection tests as well as the lower average unit cost of in-clinic tests as compared to home test kits, CHBRP assumes for modeling purposes that health plans and policies out of compliance with the HRSA recommendation at baseline would be most likely to cover in-clinic self-collection tests to reach compliance. AB 1906 would then require those health plans and policies to newly cover home test kits without cost sharing starting in January 2027. **If this assumption of implementation of the HRSA recommendation is incorrect, CHBRP's estimate of the cost impacts of AB 1906 would be smaller by magnitudes**.
- CHBRP uses 2024 claims data across all market segments to determine baseline volume of cervical cancer screening utilization overall. CHBRP assumes that 1% of that testing is done through home test kits. This is an analyst estimate that accounts for the Teal Wand's recent market entry. This estimate was reviewed with a content expert.[18]
- CHBRP assumes that the above-mentioned 1% baseline utilization of home test kits is attributable to enrollees with baseline coverage without cost sharing (40% of enrollees in state-regulated health insurance). Given that the Teal Wand is newly FDA authorized and more costly than other testing options, CHBRP assumes that very few people who do not have baseline coverage without cost sharing are using the home test kits at baseline. CHBRP has determined that this population is so small that it is unlikely to have a marginal impact on cost.
- Although Medi-Cal plans report covering home test kits at baseline, access is limited by the Teal Wand's current distribution model.
- AB 1906 mandates coverage without cost sharing for annual home test kits for cervical cancer screening, although clinical guidelines commonly recommend less frequent screening; HRSA recommends that women at average risk should not be screened more than once every 3 years. However, clinical practice does not always adhere to guidelines. Any over-screening conducted in clinical practice is captured in CHBRP's analysis through claims data.
- As of April 2026, two devices – the Teal Wand and the BD Onclarity HPV Assay – were authorized and cleared, respectively, by the U.S. FDA for home self-collection for cervical cancer screening. The Teal Wand is currently the only such home test kit for cervical cancer screening available for use, as the BD Onclarity HPV Assay gained FDA clearance for at-home use on April 8, 2026 (Reuters, 2026).
    - CHBRP analyzed the current market of FDA-approved (including cleared and authorized) home test kits but is aware that it will change over time with likely new market entrants. For more information, see the *Long-Term Impacts* section.
    - CHBRP assumes that the cost of the required Teal provider telehealth consultation is bundled into the unit cost of the home test kit and is not separately billed. CHBRP is aware that telehealth may be a limitation for some users with limited access to digital infrastructure or with insufficient technical capabilities.
    - CHBRP assumes the average cost per home test kit for cervical cancer screening is $249 for commercial and CalPERS plans (Teal Health, 2026). CHBRP uses a standard commercial-to-Medicaid cost ratio to assume a unit cost of $77.19 for Medi-Cal enrollees (31% of commercial cost). Modeling is sensitive to this price assumption, and the results will be different if plans negotiate a different price than $249 with Teal Health.
- CHBRP assumes that home test kits for cervical cancer screening are adjudicated under the medical benefit.

[18] Estimate reviewed with content expert George Sawaya, MD, University of California, San Francisco, March 13, 2026.

Approach and Assumptions on Postmandate Coverage and Utilization

- For enrollees with baseline coverage without cost sharing for home test kits (40% of enrollees), CHBRP projects a 2% increase in utilization attributable to the awareness and salience effects of AB 1906 (Robertson and Netter Epstein, 2025). This estimate reflects the mandate-driven awareness channel, including media coverage and health plan communications. Additionally, manufacturer marketing and direct-to-consumer advertising by Teal Health may independently increase demand regardless of the mandate.
- For enrollees gaining coverage without cost sharing due to AB 1906 (60% of enrollees), CHBRP projects a 10% increase in utilization, composed of 8% from the removal of cost sharing and 2% from the increased convenience of at-home testing.
- CHBRP's projected increase in utilization postmandate reflects a combination of enrollees switching from in-clinic screening to at-home screening and new screening uptake among enrollees who were not previously screened.

Offsets

CHBRP uses the term "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 synthesized the evidence and calculated that there would be no measurable cost offsets as a result of AB 1906. Positive HPV results from home test kits could generate additional follow-up clinical evaluations (e.g., cytology, colposcopy, biopsy), particularly to the extent that AB 1906 increases net new screening. Any downstream cost effects from follow-up clinical evaluations are not quantified in CHBRP's 1-year cost projection. Subject matter expertise indicates that in the short term, many early adopters of home kits would be convenience-driven substituters who would have been screened in-clinic in the absence of a home test kit but prefer the at-home option. This is understood to generally be a low-risk population, suggesting a high substitution rate and minimal net new screening in the short term. Because CHBRP's cost analysis captures a period of predominantly substitution-driven adoption, downstream follow-up costs from marginal new screenings are minimal and are not separately quantified.[19]

For further details on the underlying data sources, methods, and assumptions used in this analysis, please see the Technical Brief on AB 1906, available at www.chbrp.org.

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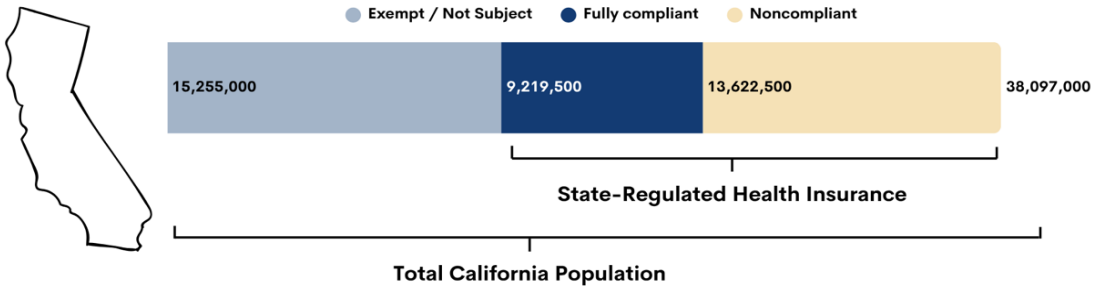
[19] Discussion with content expert George Sawaya, MD, University of California, San Francisco, on March 13, 2026.

AB 1906 Impacts: Benefit Coverage and Cost

Benefit Coverage

CHBRP estimates that at baseline, 40% (9.2 million) of the 22,842,000 enrollees in state-regulated health insurance subject to AB 1906 have coverage for home test kits for cervical cancer screening without cost sharing (Figure 3). Sixty percent (60%) of enrollees (13.6 million) would gain coverage for home test kits for cervical cancer screening without cost sharing as a result of AB 1906. For additional details on impacts to benefit coverage, see Table 4 in the Appendix.

Figure 3. California Health Insurance and Baseline Compliance With AB 1906



Utilization and Unit Cost

At baseline, CHBRP estimates that 13% of women enrolled in state-regulated commercial plans and 8% of women enrolled in state-regulated Medi-Cal plans aged 30 to 65 years use cervical cancer screening services annually, with 1% of those screenings conducted using home test kits. Postmandate, CHBRP estimates an increase from 1,045 to 6,798 enrollees using home test kits, an increase of 5,753 users. This increase reflects a split utilization model: for enrollees with existing coverage without cost sharing (40% of enrollees), CHBRP estimates a 2% increase attributable to increased awareness of the at-home screening option. For enrollees gaining coverage without cost sharing due to AB 1906 (60% of enrollees), CHBRP estimates a 10% increase driven by the removal of cost sharing and the increased convenience of home testing.

The average unit cost of the Teal Wand would increase from $87.69 at baseline to $223.71 postmandate, reflecting a shift in the composition of enrollees using the benefit rather than a change in per-kit price (for details, see the *Analytical Assumptions* section of the Technical Brief on AB 1906). Competitive pricing pressure from additional market entrants and plan-negotiated rates could influence unit costs over time. For more information, see the *Long-Term Impacts* section.

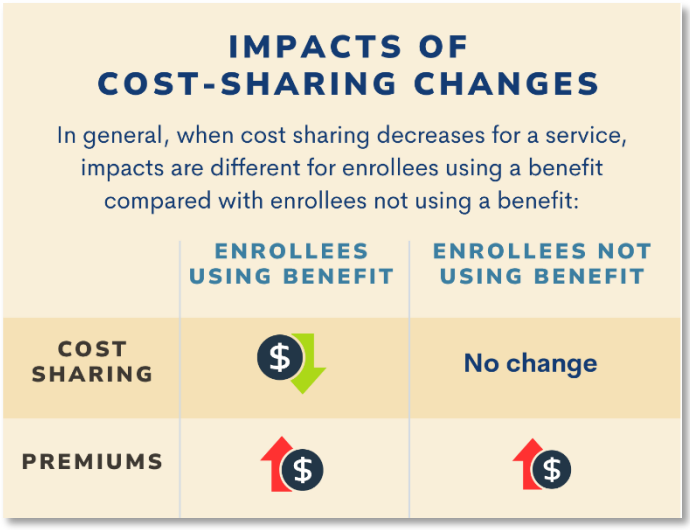
CHBRP's projected increase in utilization postmandate reflects a combination of switching from in-clinic screening to at-home screening and new screening uptake. Table 1 provides estimates of the impacts of AB 1906 on utilization and unit cost of home test kits for cervical cancer screening.

Table 1. Impacts of AB 1906 on Utilization and Unit Cost, 2027

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Number of enrollees using home test kits for cervical cancer screening	1,045	6,798	5,753	550%
Average per unit cost	$87.69	$223.71	$136.01	155%

Source: California Health Benefits Review Program, 2026.

Expenditures and Premium Impacts



Policies affecting health insurance benefits, such as benefit coverage mandates, impact stakeholders in distinct ways. In terms of direct costs, these stakeholders can generally be grouped into two categories: (1) enrollees who utilize the benefit,[20] and (2) those who pay for the benefit but do not utilize it. All enrollees within a risk pool share in these costs through the benefit's impact on plan premiums. Enrollees who use a benefit may be responsible for paying premiums and any out-of-pocket expenses related to the benefit.

Expenditure Impacts on Employers and All Enrollees

As shown in Figure 4, for DMHC-regulated plans and CDI-regulated policies, AB 1906 would increase total premiums paid by employers and enrollees by approximately $1,580,000 (0.0009%). The majority of the premium impact falls on commercial market segments, which would newly cover the benefit. The $2,000 increase in Medi-Cal premiums reflects the marginal awareness-driven utilization among beneficiaries who already have baseline coverage without cost sharing at a lower reimbursement rate ($77.19 per kit). For more details about per member per month (PMPM) premium impacts, see Table 2 (for annual impacts, see Table 5 and Table 6 in the Appendix).

Figure 4. Expenditure Impacts of AB 1906 on Employers and Enrollees

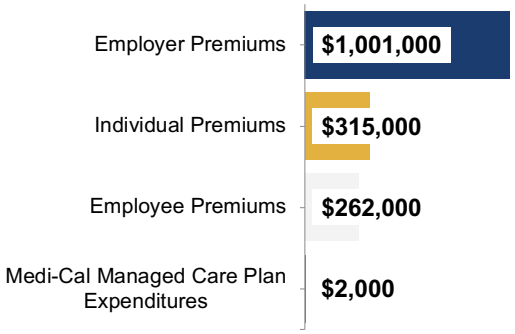


Table 2. Premium Impact Ranges of AB 1906 by Market Segment

Market Segment	Premium Impact Range (PMPM)
Commercial plans/policies	$0.0094 – $0.0099
Covered California – individually purchased	$0.0105– $0.0111
CalPERS	$0.0074
Medi-Cal	$0.00002

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

[20]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 a health insurance plan in the individual market may pay both insurance premiums and cost sharing or other out-of-pocket expenses.

Below, Table 3 provides estimates of the aggregate impacts of AB 1906 on premiums.

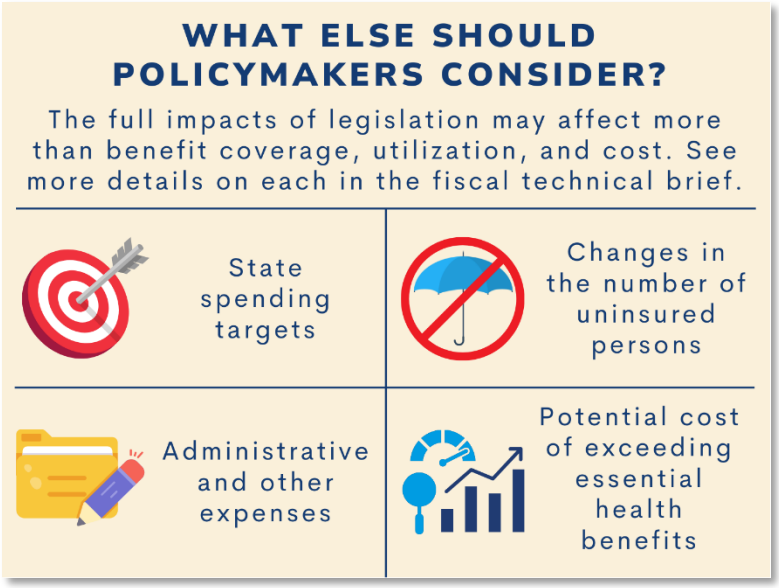
Table 3. Impacts of AB 1906 on Premiums, 2027

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Non-enrollee premiums				
Employer-sponsored (a)	$75,730,916,000	$75,731,848,000	$932,000	0.0012%
CalPERS employer (b)	$8,611,855,000	$8,611,924,000	$69,000	0.0008%
Medi-Cal (c)	$42,982,384,000	$42,982,386,000	$2,000	0.0000%
Enrollee premiums				
Enrollees, individually purchased insurance	$25,775,325,000	$25,775,640,000	$315,000	0.0012%
Outside Covered California	$9,551,761,000	$9,551,871,000	$110,000	0.0012%
Through Covered California	$16,223,564,000	$16,223,769,000	$205,000	0.0013%
Enrollees, group insurance (d)	$21,828,135,000	$21,828,397,000	$262,000	0.0012%
Total premiums	$174,928,615,000	$174,930,195,000	$1,580,000	0.0009%

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.
(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

CHBRP defines enrollee expenses as cost sharing for covered benefits and out-of-pocket expenses for non-covered benefits. As mentioned above, CHBRP assumes that enrollees using home test kits for cervical cancer screening at baseline are not subject to cost sharing. As a result, AB 1906 is not projected to result in measurable changes to enrollee cost-sharing expenses. Although the mandate would expand coverage without cost sharing to 60% of enrollees who currently lack it, CHBRP assumes that very few enrollees without baseline coverage are currently purchasing home test kits out of pocket. Therefore, the reduction in out-of-pocket expenses for this population is negligible.



See more information in the Technical Brief on AB 1906, 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, administrative and other expenses, and the potential cost of exceeding EHBs.

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AB 1906 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[21] of AB 1906 on access and adherence to recommended cervical cancer screening guidelines, including the proportion of individuals who are up to date with screening and overall uptake, structural and psychosocial barriers to screening, and early detection and prevention of cervical cancer among underscreened populations. See the *Long-Term Impacts* section for discussion of premature death, economic loss, and social determinants of health.

Estimated Public Health Outcomes

As presented in the *Overview* section, there is very strong evidence that FDA-approved home test kits, and others that use similar processes and technology, are effective for cervical cancer screening through the detection of HPV.

As presented in the *Benefit Coverage and Cost Impacts* section, at baseline, 40% of enrollees with state-regulated health insurance have coverage without cost sharing for home test kits for cervical cancer screening. Postmandate, 100% of enrollees in state-regulated health insurance would have coverage compliant with AB 1906. CHBRP projects a 2% increase in utilization among enrollees with baseline coverage without cost sharing, resulting in an estimated increase in home kit use among these enrollees. This awareness-driven increase among enrollees with baseline coverage without cost sharing reflects media coverage, provider education, and health plan member communications about the at-home option. For the 60% of enrollees who do not have baseline coverage without cost sharing, CHBRP projects a 10% postmandate utilization rate (8% from the removal of cost sharing, plus 2% from increased convenience). Overall, CHBRP estimates that AB 1906 would result in 5,753 new users of home cervical cancer screening kits.

In the short term, the majority of new home test kit utilization postmandate would come from enrollees gaining coverage without cost sharing under the mandate. The increase in utilization would primarily reflect switching from in-clinic screening to at-home screening among women already participating in routine screening, although there is potential for new uptake among underscreened populations. Given the minimal change in utilization overall, CHBRP concludes that the passage of AB 1906 would have no measurable short-term public health impacts. In addition, CHBRP concludes that AB 1906 would have no measurable impact on disparities in health outcomes by age, race/ethnicity, income, education, or other determinants as utilization is expected to largely reflect a shift from in-clinic screening to at-home screening among women that are already up to date. Additionally, no short-term impacts are expected on premature death and societal economic losses.

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

AB 1906 Impacts: Long-Term

In this section, CHBRP estimates the long-term impact of AB 1906, which CHBRP defines as impacts occurring beyond the first 12 months after legislation is fully implemented.[22] 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

Long-term utilization of home test kits for cervical cancer screening will change as a result of multiple factors over time. Although the Teal Wand is currently the only FDA-authorized home cervical cancer screening device available for use, additional market entrants could broaden access and adoption. On April 8, 2026, the FDA cleared the BD Onclarity HPV Assay for at-home use; the test is expected to be available in the coming months (Reuters, 2026). This clearance may indicate near-term movement toward additional home kit approvals. Additionally, some health systems in California are planning their own self-collection screening programs outside of the Teal mechanism, using their own laboratories and mailing infrastructure, similar to the approach used for colorectal cancer Fecal Immunochemical Test (FIT) programs.[23] Given the volume of possible near-term entrants to the home test kit market, it is possible that the market will become more competitive in a relatively short time horizon; this has the potential to loosen the current telehealth safeguards built into Teal's process as the technology matures.[24]

Provider and user adoption may also accelerate as health systems integrate self-collection into routine electronic health record–based outreach workflows and as enrollees become more familiar with the home test option.

Additional influences may include expanded health plan outreach, advances in self-collection technology, integration of home kits into routine clinical workflows, and direct-to-consumer marketing. Additional administrative data and follow-up protocols from the NCI-sponsored SHIP Trial, which formally evaluated the noninferiority of self-collection–based sampling approaches compared with clinician-collected samples, may also support future developments in home test kits.

Cost Impacts

Long-term increased utilization of home cervical cancer screening kits would lead to increased cost, as premiums would increase concurrent with increased adoption. The cost per kit ($249 for commercial/CalPERS, $77.19 for Medi-Cal) may decrease over time if additional manufacturers receive FDA approval, introducing competitive pricing pressure.

Starting in October of 2028, DHCS will begin implementing cost sharing for Medi-Cal plans per H.R.1. It is possible that this change will impact long-term cost impacts for AB 1906; however, as Medi-Cal has not historically imposed cost sharing, the difference is unknown. Per H.R.1, cost sharing may not exceed $35 per service. Although the ACA covers certain preventive services without cost sharing (see the *Policy Context* section), H.R.1 does not exempt preventive services from Medicaid cost sharing. If Medi-Cal beneficiaries become subject to cost sharing for home test kits under

[22] 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 1906. 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 represents ongoing annual costs at full-scale implementation of AB 1906, 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.
[23] Discussion with content expert George Sawaya, MD, University of California, San Francisco, on March 13, 2026.
[24] Discussion with content expert George Sawaya, MD, University of California, San Francisco, on March 13, 2026.

H.R.1, this could reduce utilization gains projected under AB 1906 for Medi-Cal beneficiaries, though the magnitude of this effect is unknown.

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

In the case of AB 1906, home test kits for cervical cancer screening could help reduce barriers associated with traditional in-clinic screening. Specifically, when implemented as a part of targeted outreach strategies by clinicians and health plans, home test kits could, over time, improve cervical cancer screening rates among underscreened populations that have been historically more difficult to reach, such as racial/ethnic, sexual, and religious minorities (Fuzzell et al., 2021).

Impacts on Disparities and the Social Drivers of Health[25]

Expanded access to home test kits for cervical cancer screening through AB 1906 could help to address barriers identified in the *Background* section that currently limit access to cervical cancer screening. Structural barriers to screening, such as limited access to health care facilities, shortages of trained health care personnel, insufficient resources, and long wait times for appointments, could be addressed. Home test kits may also improve adherence to screening among women who are underscreened due to cultural, religious, or personal reasons.

CHBRP estimates that AB 1906 could modify the effects of the social drivers of health (SDOH) on cervical cancer screening by reducing barriers to screening over time.

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).[26] Evidence shows that cervical cancer is a significant contributor to YPLL, and is a leading cause of premature deaths among HPV-related cancers, accounting for 65% of all HPV-related YPLL among women (Priyadarshini et al., 2021). Early screening and detection have been associated with improved health outcomes, with studies revealing that women who are up to date with their cervical cancer screening are less likely to die from the diagnosis (Peirson et al., 2013; Perkins et al., 2023). Therefore, access to screening through AB 1906 among underscreened populations would likely reduce YPLL.

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.

Direct costs associated with cervical cancer in the United States have been estimated to total $2.3 billion in 2020 alone (CDC, 2025). In addition to direct medical expenses, cervical cancer can also contribute to economic loss through reduced productivity and premature death. Early screening and detection can reduce these costs, and at-home screening

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

can also lower indirect costs by minimizing the need to take time off from work to attend in-clinic appointments. Additionally, evidence from economic evaluation of home test kits shows that compared to the standard of care, they are cost-effective and associated with increased screening uptake (Meenan et al., 2023).

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Appendix. Impacts of AB 1906 on Benefit Coverage and Expenditures, 2027

Table 4. Impacts of AB 1906 on Benefit Coverage, 2027

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Total enrollees with health insurance subject to state benefit mandates*	22,842,000	22,842,000	0	0.00%
Total enrollees with health insurance subject to AB 1906	22,842,000	22,842,000	0	0.00%
Number of enrollees with fully compliant coverage for mandated benefit	9,219,500	22,842,000	13,622,500	147.76%
Percent of enrollees with fully compliant coverage for mandated benefit	40%	100%	60%	147.76%

Source: California Health Benefits Review Program, 2026.
Note: * Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.[27]
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; DMHC = Department of Managed Health Care.

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

Table 5. 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 Policies (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)	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 1906	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)	$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.
(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.[28]
(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.

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

Table 6. Postmandate Change in Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2027

	DMHC-Regulated						CDI-Regulated			Total
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Policies (by Market) (a)			
	Large Group	*Small Group*	*Individual*	*CalPERS (b)*	*Medi-Cal (Excludes COHS) (c)*		*Large Group*	*Small Group*	*Individual*	
					Under 65	*65+*				
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	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 1906	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)	$0.0077	$0.0066	$0.0000	$0.0062	$0.0000	$0.0000	$0.0078	$0.0067	$0.0000	$1,004,000
Average portion of premium paid by enrollee	$0.0017	$0.0033	$0.0105	$0.0012	$0.0000	$0.0000	$0.0019	$0.0028	$0.0111	$576,000
Total premium	$0.0094	$0.0099	$0.0105	$0.0074	$0.0000	$0.0000	$0.0097	$0.0095	$0.0111	**$1,580,000**
Enrollee expenses										
Cost sharing for covered benefits (deductibles, copays, etc.)	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0
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	$0.0094	$0.0099	$0.0105	$0.0074	$0.0000	$0.0000	$0.0097	$0.0095	$0.0111	**$1,580,000**
Percent change										
Premiums	0.0012%	0.0012%	0.0012%	0.0008%	0.0000%	0.0000%	0.0010%	0.0012%	0.0013%	0.0009%
Total expenditures	0.0012%	0.0010%	0.0009%	0.0007%	0.0000%	0.0000%	0.0009%	0.0009%	0.0011%	0.0008%

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.
(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.[29]
(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.

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

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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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