A REPORT TO THE 2025–2026 CALIFORNIA LEGISLATURE

Bill Analysis Report: California Assembly Bill 1970 Mental Health or Substance Use Disorders

APRIL 14, 2026

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

chbrp.org

KEY FINDINGS

Analysis of California Assembly Bill 1970 Mental Health or Substance Use Disorders

Summary to the 2025-2026 California State Legislature, April 14, 2026

CHBRP

Summary

The version of California Assembly Bill (AB) 1970 analyzed by California Health Benefits Review Program (CHBRP) would prohibit step therapy as a prerequisite to coverage of any prescription drug used for the treatment of serious mental illness (SMI) or substance use disorders (SUDs). The step therapy prohibition does not apply when the FDA-labeled indications and usage of a drug indicate that some prior medication must be taken.

Background

Step therapy, a type of utilization management, may be applied to prescription drugs by health plans and insurers to control costs, ensure medication compatibility, and manage safety. Some plans and insurers have step therapy requirements for the prescription drugs used to treat SMI and SUDs.

Benefit Coverage

If enacted, AB 1970 would apply to the health insurance of 22,842,000 enrollees (60% of all Californians), including those with commercial or CalPERS health insurance and those enrolled in Medi-Cal. AB 1970 would not exceed essential health benefits. Medi-Cal beneficiaries are not subject to step therapy for these drugs, so their coverage is compliant with AB 1970.

Medical Effectiveness

CHBRP found *some evidence* that step therapy requirements for prescription drugs used to treat SMI decrease utilization of those drugs and increase hospitalizations. However, these findings should be interpreted with caution because some of the studies analyzed older atypical antipsychotic drugs that are no longer subject to step therapy. CHBRP did not identify any direct evidence on the effect of step therapy requirements for prescription drugs used to treat SMI on health outcomes.

Few studies directly compare branded versus generic drugs for SMI; most evidence relies on statistical methods to indirectly compare findings from placebo-controlled studies. CHBRP found *some evidence* that branded atypical antipsychotics are less effective than generic atypical antipsychotics at reducing symptoms of bipolar disorder and schizophrenia.

CHBRP did not identify any studies regarding the effects of step therapy requirements for prescription drugs used to treat SUDs or the comparative effectiveness of prescription drugs used to treat SUDs.

Cost Impacts

The immediate utilization impact of AB 1970 is projected to be a small shift from generic to branded SMI and SUD drugs among a narrow subset of affected enrollees. Postmandate, CHBRP estimates there would be no net change in the number of enrollees using SMI or SUD drugs, however, an estimated 300 enrollees accessing drugs currently subject to step therapy would shift from generic to branded drugs. An additional $2,440,000 in total annual premiums would be paid by employers and enrollees due to the use of higher-cost drugs to treat SMI and SUDs. Of this, annual enrollee premiums — which include premiums for enrollees using and not using the benefit — would increase by a total of $859,000. Enrollee cost sharing would increase by a total of $158,000.

Public Health Impacts

It is not expected that the shift from utilization of generic to branded drugs for SMI and SUD as a result of AB 1970 would have an impact on public health outcomes.

Long-Term Impacts

Over the longer term, new branded SMI and SUD prescription drugs may appear on the market, potentially changing the number of patients using branded drugs. If this occurs, per-member costs could rise. If generic versions of currently branded SMI and SUD prescription drugs enter the market, per-member costs could decrease over time.

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Acronyms and Terminology

Acronyms

AB – Assembly Bill

ACA – Affordable Care Act

AUD – alcohol use disorder

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

ED – emergency department

EHB – essential health benefits

FDA – U.S. Food and Drug Administration

HRSA – Health Resources and Services Administration

LAI – long-acting injectables

MAUD – medications for alcohol use disorder

MOUD – medications for opioid use disorder

MHPAEA – Mental Health Parity and Addiction Equity Act

NDC – national drug code

OUD – opioid use disorder

PA – prior authorization

SMI – serious mental illness

SAMHSA – Substance Abuse and Mental Health Services Administration

SB – Senate Bill

SDOH – social drivers of health

SNRI – serotonin and norepinephrine reuptake inhibitors

SSRI – selective serotonin reuptake inhibitors

SUD – substance use disorder

TAR – treatment authorization request

Terminology

CHBRP uses the following terminology for this analysis:

Coverage-related:

Prior authorization (PA):[1] Also known as precertification, prior approval, or prospective review, PA 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). PA was developed as a 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 PA 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

[1] More information about prior authorization is available in CHBRP's 2023 analysis *Prior Authorization in California*.

treatment. PA 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 PA for nonpreferred medications can encourage the use of preferred medications that can be procured at a lower price.

Step therapy: Also known as "fail-first" protocols, step therapy may be applied to prescription medications by health plans and insurers to control costs, ensure medication compatibility, and manage safety. Health plans/insurers may use step therapy protocols to apply clinical guidelines established by professional societies and other recognized organizations to treatment plans. They require an enrollee to try and fail one or more medications prior to receiving coverage for the initially prescribed medication. Step therapy protocols usually recommend starting with a medication that is less expensive (generics) and/or has more "post-marketing safety experience" (PBMI, 2015).

- **Step therapy** as defined for this bill in Insurance code 10123.201: "Step therapy" means a type of protocol that specifies the sequence in which different prescription drugs for a given medical condition and medically appropriate for a particular patient are to be prescribed.

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).

SMI/SUD-related and/or bill specific:

FDA-labeled indications and implicit step therapy: The FDA-approved labeling for a drug defines its indicated uses, recommended dosing, and any prerequisites for use. For certain serious mental illness (SMI) and substance use disorder (SUD) medications (e.g., long-acting injectables [LAIs]), the FDA label itself may require that a patient first be established on an oral formulation of the same medication before transitioning to the injectable form. This is intended to assess tolerability and confirm therapeutic response prior to initiating a longer-acting formulation. In this way, the FDA label functions as a form of implicit step therapy, as it mandates a prior treatment step before the drug can be appropriately initiated. For example, the labeling for some LAI antipsychotics requires an oral stabilization period before the first injection is administered. Payers and utilization management programs may reference these FDA-labeled prerequisites when establishing PA or TAR criteria, meaning that clinical step therapy requirements may be grounded in, and consistent with, the drug's own approved labeling rather than solely imposed by the health plan.

Medical benefit: Drugs that are physician-ordered and administered under the supervision of a physician, generally in a hospital, clinic, or infusion center, are typically covered through the medical benefit. This coverage includes the associated hospital stay or office visit. In the context of SMI and SUD, this often applies to medications such as LAI antipsychotics (e.g., administered in a clinic setting), intravenous or intramuscular treatments, and medically supervised detoxification agents.

Medi-Cal Rx: The pharmacy benefit program for Medi-Cal. Medi-Cal Rx is administered by the Department of Health Care Services (DHCS) and covers outpatient prescription drugs for Medi-Cal beneficiaries. For SMI and SUD, this includes coverage of antipsychotics, mood stabilizers, medications for OUD, and other behavioral health drugs dispensed at the pharmacy.

Medi-Cal medical benefit (drug coverage): Certain drugs administered in a clinical setting continue to be covered under the medical benefit in Medi-Cal, rather than through Medi-Cal Rx. These include physician-administered medications such as LAI antipsychotics given in a provider's office, infusion therapies, and drugs administered during an inpatient stay or outpatient visit.

Pharmacy benefit: Covers outpatient prescription drugs, typically those filled at a retail pharmacy, mail-order pharmacy, or specialty pharmacy. For individuals with SMI and SUD, this commonly includes oral antipsychotics, mood stabilizers, antidepressants, and medications for opioid use disorder (OUD) such as buprenorphine or naltrexone in oral or film form.

Serious mental illness: As defined in subdivision (b) of Section 5600.3 of the Welfare and Institutions Code,[2] includes schizophrenia, bipolar disorder, post-traumatic stress disorder, as well as major affective disorders or other severely disabling mental disorders.

Treatment authorization request (TAR): A PA mechanism used in Medi-Cal to request approval for certain medications, services, or levels of care before they are provided. TARs apply to both the medical and pharmacy benefits, meaning they may be required for physician-administered drugs billed during an office visit or clinical setting, as well as for outpatient drugs dispensed through Medi-Cal Rx. In the context of SMI and SUD, TARs are particularly relevant for LAI antipsychotics administered in a clinical setting, where clinical criteria must be met.

[2] Welfare and Institutions Code Section 5600.3 (2025). https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=5600.3.

Overview: AB 1970 and Mental Health or Substance Use Disorders

On February 13, 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) 1970, Mental health or substance use disorders, as amended on March 24, 2026.

Bill Language of AB 1970

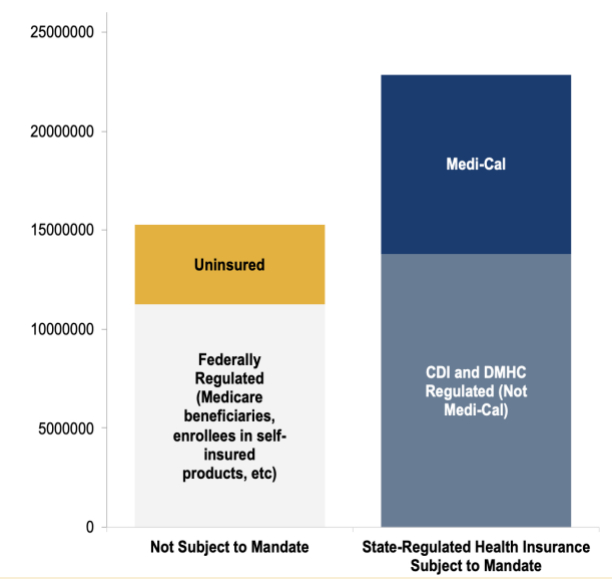
AB 1970 would prohibit a plan or policy from imposing step therapy as a prerequisite to authorizing coverage of any prescription drug used for the treatment of serious mental illness (SMI) or substance use disorders (SUDs), as defined. The prohibition on step therapy does not apply when the U.S. Food and Drug Administration (FDA)-labeled indications and usage of a drug indicate that some prior medication must be taken. AB 1970 would take effect January 1, 2027.

See the full text of AB 1970 in CHBRP's Technical Brief on AB 1970, available at www.chbrp.org.

If enacted, AB 1970 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).

Figure 1. Health Insurance in CA and AB 1970



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.

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.[4]

CHBRP provides an overview of common utilization management practices including step therapy that are addressed by AB 1970 in its explainer *Utilization Management: An Overview*.

Serious Mental Illness and Substance Use Disorder Prevalence in California

SMI is defined as a diagnosable mental, behavioral, or emotional disorder (within the past year) in a person aged 18 years or older that substantially interferes with their life and ability to function (SAMHSA, 2024a). For the purpose of this bill, California code[5] states that SMI includes but is not limited to diagnoses of schizophrenia, bipolar disorder, post-traumatic stress disorder, and major affective disorders or other severely disabling mental disorders. Per the bill language, SUD

[3] See CHBRP's authorizing statute.
[4] For more detail, see CHBRP's resource *Sources of Health Insurance in California*.
[5] WIC § 5600.3

means a substance-related and addictive disorder (encompassing major sub-types of opioid use disorder, alcohol use disorder, and the residual substances) as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

SMI and SUD are pressing health challenges in California. Between 2022 and 2023, 31.4% of California adults had a mental illness or SUD in the past year (KFF, n.d.). More than 1.2 million adults in California live with SMI (DHCS, n.d.). In 2019, nearly 1 in 6 California adults experienced a mental illness, with one in 26 California adults experiencing SMI that resulted in difficulty carrying out major life activities (Holt and Hahn, 2022). Estimates of the prevalence of schizophrenia and related psychotic disorders in the United States range between 0.25% and 0.64% (NIMH, n.d.-b). An estimated 2.8% of U.S. adults had bipolar disorder in the past year, with an estimated 4.4% of U.S. adults experiencing bipolar disorder at some time in their lives (NIMH, n.d.-a). An estimated 21.0 million adults in the United States had at least one major depressive episode, representing 8.3% of all U.S. adults (NIMH, 2023). Although the exact prevalence of schizoaffective disorder is not known, experts estimate that it ranges from 0.2% to 0.5% (NIMH, n.d.-b). Opioid use disorder prevalence in California was 1.86% among people aged 12 years and older in 2021 (SAMHSA, 2023). Alcohol use disorder prevalence in California was 10.43% among people aged 12 or older in 2021 (SAMHSA, 2023).

Co-occurring mental illness and SUDs are common in the United States. Adults with mental illness in the United States are more likely to use illicit drugs, binge drink, and are at a higher risk of developing an SUD compared to those without mental illness (SAMHSA, 2019). Similarly, individuals with SUD are particularly vulnerable to developing mental health conditions and other costly chronic diseases like HIV, hepatitis C, heart disease, and chronic pain (NIDA, 2024). Common risk factors contribute to both substance use and mental illness, including an individual's genes, social environment, and other life circumstances like traumatic experiences (NIDA, 2024).

Approximately 21.2 million U.S. adults had a co-occurring SUD and any mental illness in 2024, including 2.6% of U.S. adults aged 18 and older with a co-occurring SMI and SUD (SAMHSA, 2025b). Roughly 33% of adults aged 18 and over in the United States with any mental illness also have an SUD (SAMHSA, 2024b). An analysis of 2015 national mental health outcome measures reported to SAMHSA found that 34.4% of California adults who were utilizing county mental health services had co-occurring SMI and SUD (Holt and Looby, 2018). Diagnosing and treating co-occurring substance use and other mental disorders is complex, because patients may have overlapping symptoms and symptoms that are more persistent, severe, and resistant to treatment compared with patients who have either disorder alone (NIDA, 2024).

Among California adults with any mental illness, slightly more than one-third reported receiving mental health services, which include treatment, counseling, or prescription medication during the past year, lower than the national rate of 43.6% (Holt and Hahn, 2022). While adults in California with SMI were more likely to receive treatment than adults with any mental illness, 40% did not receive any mental health services (Holt and Hahn, 2022).

What Drugs Are Used to Treat Serious Mental Illness or Substance Use Disorders?

The treatment of SMI and SUDs can involve pharmacotherapy, psychotherapy, or a combination of both. CHBRP's analysis of SMI and SUDs focuses solely on psychopharmacology carried out by licensed providers including psychiatrists, psychiatric clinical nurse specialists, and pharmacists; other types of treatments including psychotherapy are not included.

There are many different types of drugs used to treat SMI and SUDs due to the large number of disorders that they represent (SAMHSA, 2025a). Over the past several years, new drugs to treat SMI and SUDs have come on the market, including new antipsychotics, antidepressants, and long-acting injectable (LAI) formulations of medications. Some insurers have implemented utilization management approaches to these newer drugs (e.g., formularies, prior authorization [PA], step therapy requirements). Step therapy requires that enrollees must try less expensive, generic medications before receiving approval for the more expensive, nongeneric medications – e.g., atypical antipsychotics, atypical antidepressants, and LAIs to treat SMI and SUDs.

Disparities in Serious Mental Illness and Substance Use Disorders and Barriers to Accessing Treatment

Disparities in SMI and SUDs in California are pronounced across race, ethnicity, gender, sexual orientation, age, and income, and are influenced by social drivers of health (CDPH, 2024). American Indian, Alaska Native, Black, Latino, and multiracial populations experience higher rates of SMI, substance-related hospitalizations, and overdose deaths, with disparities compounded by limited access to treatment and provider bias (CDPH, 2024; Holt and Hahn, 2022; Kelleher et al., 2025). Men face higher rates of substance-related mortality, while women experience more co-occurring disorders and barriers to treatment; LGBTQ+ individuals have elevated rates of substance use (NIDA, 2017). Younger adults and low-income populations show higher prevalence of SMI and SUDs, while many adolescents and adults experience delayed or unmet treatment needs. Addressing these disparities requires considering both health coverage policies and social factors such as housing, education, and income that shape risk and access to care.

Access to treatment for SMI and SUD is impeded by system- and provider-level barriers. Insurance requirements such as PA, formulary restrictions, and step therapy delay initiation of medications, reducing patient readiness and continuity of care (AMA, 2022; Latronica et al, 2021). Federal and state regulations and pharmacy practices can further limit access to medications like buprenorphine and naltrexone, while provider shortages, uneven geographic distribution, and provider discomfort treating SUD constrain availability. Patient-level barriers, including stigma, prior negative treatment experiences, logistical challenges, and knowledge gaps, further reduce engagement with care.

SMI and SUD in California and the United States create substantial economic and societal costs, with lifetime costs of SMI estimated at $1.85 million per person with a diagnosis by the age of 25 and SUD-related losses (including health care, criminal justice, and reduced quality of life) in California approximating $172.6 billion annually (ACP, 2020; Seabury et al., 2019; DHCS, 2013). Addiction-related medical consequences account for 12 to 15% of all California health care spending (Los Angeles County Department of Public Health, 2025). Public payers, including Medicaid, cover the majority of these costs, yet current spending falls far short of what would be needed to provide evidence-based care to all residents in need (CMS, n.d.). Beyond direct medical costs, most of the economic burden stems from lost productivity, crime, and early mortality, with SUDs contributing to an estimated 25,000 deaths annually in California.

For an in-depth look at clinical guidance, existing disparities, and barriers to access to care for drugs to treat SMI and SUD, please see the *Background on Serious Mental Illness and Substance Use Disorders* section in CHBRP's Technical Brief on AB 1970.

Step Therapy Requirements for Prescription Drugs Used to Treat SMI and SUDs

CHBRP's medical effectiveness literature review focused on determining the impact of step therapy requirements for prescription drugs used to treat SMI and SUDs, specifically on utilization of these drugs, health outcomes, and utilization of other health care services.

Measurable health outcomes relevant to AB 1970 include mental health crises, overdoses, symptom severity, and relapse. Additional outcomes include utilization of other services (e.g., outpatient visits, emergency department [ED] visits, and hospitalizations). For the detailed medical effectiveness review, please see the *Medical Effectiveness* section in CHBRP's Technical Brief on AB 1970.

There is *some evidence* based on six studies that step therapy requirements decrease utilization of prescription drugs for SMI that require step therapy. In a previous bill analysis (AB 2144), CHBRP identified four studies on step therapy for prescription drugs used to treat SMI; these studies found that utilization of drugs that require step therapy decreased after step therapy was implemented.[6] One study found that step therapy increased the risk of discontinuing treatment with any antipsychotic, and one found a decrease in the number of days supplied for any antidepressant. Two retrospective observational studies cited delays and decreased utilization of cariprazine (Vraylar) or any atypical antipsychotic after an

[6] See CHBRP's analysis of AB 2144 (2022), available at: https://chbrp.org/completed_analyses/index.php

initial cariprazine claim was rejected; however, claims were rejected for a number of formulary-related reasons and step therapy accounted for only a small percentage of those claim rejections.

CHBRP found *some evidence* that step therapy requirements for antidepressants and atypical antipsychotics used to treat SMI increase hospitalizations and in some cases outpatient and ED visits. However, these findings should be interpreted with caution because some of the studies analyzed older atypical antipsychotic drugs that are no longer subject to step therapy. CHBRP did not identify any direct evidence of the effect of step therapy requirements for prescription drugs used to treat SMI on health outcomes. The association between step therapy and increases in hospitalizations provides indirect evidence that step therapy may lead to decreases in use of medications used to treat SMI, which could exacerbate symptoms of SMI, which would, in turn, increase the need for hospitalization. CHBRP did not identify any studies regarding the effectiveness of step therapy requirements for prescription drugs used to treat SUDs.

Comparative Effectiveness of Branded Versus Generic Drugs Used to Treat SMI and SUD

Few studies directly compare branded versus generic drugs used to treat SMI; most evidence comes from studies that use statistical methods to indirectly compare findings from studies that compare these drugs to placebo. CHBRP did not identify any studies that compared branded versus generic drugs used to treat SUDs.

CHBRP found *some evidence* that branded atypical antipsychotics are less effective than generic atypical antipsychotics at reducing symptoms related to bipolar disorder. CHBRP found *some evidence* that branded atypical antipsychotics are less effective than generic atypical antipsychotics at reducing overall, positive, and negative symptoms of schizophrenia; reducing depression symptoms; and improving social functioning among persons with schizophrenia.

CHBRP found *some evidence* that there is no difference between vortioxetine, a branded antidepressant, and generic serotonin and norepinephrine reuptake inhibitors (SNRIs) or generic selective serotonin reuptake inhibitors (SSRIs) on symptom reduction at 6 or 8 weeks among adults with major depressive disorder. CHBRP found *some evidence* that vortioxetine is associated with greater risk of major depressive disorder relapse at 6 months compared to generic SSRIs.

CHBRP did not identify any studies regarding the comparative effectiveness of prescription drugs used to treat SUDs.

Findings regarding the harms of branded versus generic atypical antipsychotics and branded versus generic antidepressants are mixed. Generic atypical antipsychotics are associated with less risk of using antiparkinsonian medication and more risk for anticholinergic side effects compared to branded atypical antipsychotics. Vortioxetine, a branded antidepressant, has a lower risk for discontinuations due to adverse events compared to generic SNRIs. Vortioxetine is associated with a significantly higher risk of nausea/vomiting than certain generic atypical antidepressants and SSRIs.

Policy Context

Existing California Law and Regulations

Enacted in 1999 and amended in 2024, California's Mental Health Parity Act goes beyond the scope of the federal Mental Health Parity and Addiction Equity Act (MHPAEA). Importantly, California law requires all state-regulated health plans and policies to provide behavioral health treatment at all levels of care (e.g., inpatient, outpatient, residential, partial hospitalization, intensive outpatient)[7]. The federal MHPAEA, in contrast, does not mandate that plans and policies provide behavioral health disorder benefits but only regulates parity with other benefits when they are covered. California law also adds network adequacy rules to the existing requirements of the MHPAEA: if in-network care isn't available, the plan or policy must cover out-of-network care at in-network costs.

[7] See CHBRP's explainer *Mental Health Parity Laws*.

AB 347 (enacted 2021) requires health care service plans, effective January 1, 2022, to expeditiously grant step therapy exceptions within specified time periods when use of the prescription drug required under step therapy is inconsistent with good professional practice. Under AB 347, California health plans must have a clear and accessible step therapy exception process. This is a stronger patient protection than most states but does not eliminate the administrative burden of the exception process itself.

SB 306, effective July 1, 2026, requires DMHC and CDI to report statistics on covered health care services subject to PA and the rate at which they are approved or modified. The bill requires the departments to identify the health care services approved at a rate that meets or exceeds the threshold rate of 90%, and, on or before July 1, 2027, publish a list of the services identified. Beginning no later than January 1, 2028, the bill requires that a plan or insurer cease requiring PA for the most frequently approved covered health care services.

Medications are FDA-approved for a specific purpose but can also be used "off-label"[8] for other purposes. Under existing law, plans and policies cannot limit or deny coverage for off-label use of prescription drugs.[9] More specifically, off-label use must be covered under state-regulated plans and policies provided that the drug is: (1) FDA-approved; (2) prescribed by a contracting licensed health care professional for the treatment of a life-threatening condition; or for the treatment of a chronic and seriously debilitating condition, the drug is medically necessary to treat that condition, and the drug is on the insurer's formulary; and (3) the drug has been recognized for treatment of that condition by the American Hospital Formulary Service's Drug Information or at least two articles from major peer-reviewed medical journals.

California's Medi-Cal Program and Opioid Use Disorder Treatment

Medi-Cal is a national leader in access to medications for opioid use disorder (OUD). It is one of only two states (with Illinois) to cover all buprenorphine formulations without benefit limitations — no step therapy or PA — making it one of the most accessible benefit designs nationally.

Essential Health Benefits and the Affordable Care Act

Prescription drugs are an essential health benefit (EHB). AB 1970 does not change the coverage requirement, it only addresses step therapy for the drugs used to treat SMI and SUD, so the proposed mandate would not exceed the current definition of EHBs in California.

Similar Legislation in Other States

Illinois enacted House Bill [HB] 5395 in 2024, prohibiting step therapy for health plans and policies as of January 1, 2026.[10] The legislation states that no policy, contract, certificate, evidence of coverage, or formulary (including for commercial and Medicaid managed care plans) shall impose step therapy requirements.

Several other states (Florida, Maryland, Massachusetts, Minnesota, New Jersey, New Mexico, and New York) have introduced legislation in 2026 related to step therapy for SMI and/or SUD.

- Florida legislation (SB 70) would require the Medicaid agency to approve drug products for the treatment of SMI without step-therapy under certain circumstances and to implement a step-therapy approval process for medications excluded from the preferred drug list.[11]
- Maryland legislation (HB 808 and SB 490) would prohibit the Maryland Medicaid program from applying a step therapy or fail-first protocol for a prescription drug used to treat adults with bipolar disorder, schizophrenia, major

[8] Off-label use refers to the practice of prescribing or using a medication for a purpose, dosage, route of administration, or patient population that is not explicitly approved by the FDA.
[9] HSC §1367.21 and INS §10123.195.
[10] https://www.ilga.gov/ftp/legislation/103/HB/10300HB5395enr.htm
[11] https://legiscan.com/FL/bill/S0070/2026

depression, post-traumatic stress disorder, or a medication-induced movement disorder associated with the treatment of SMI.[12]

- Massachusetts legislation (HB 1128) states that a carrier or utilization review organization shall not, with respect to a drug approved by the FDA for the treatment of SMI, impose PA, a step therapy protocol, or any other protocol that could restrict or delay the dispensing of the drug.[13]
- Minnesota legislation (HB 3444) states that PA or step therapy shall not be required or utilized for any class of drugs that is approved by the FDA for the treatment of OUD.[14]
- New Jersey's SB 2918 mandates that insurance carriers, including Medicaid and NJ FamilyCare, cover prescription drugs for SMI without PA or step therapy for patients 18 and older.[15] This applies when prescribed by psychiatrists, or ob-gyns during the postpartum period.
- New Mexico legislation (SB 20) states that a health insurer or pharmacy benefits manager shall not impose step therapy requirements before authorizing coverage for drugs to treat SMI or a SUD, if medically necessary, except in cases in which a biosimilar, interchangeable biologic or generic version is available.[16]
- New York legislation (AB 7522 and SB 4867) prohibits the application of fail-first or step therapy protocols to coverage for the diagnosis and treatment of serious mental health conditions.[17]

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[12] http://legiscan.com/MD/bill/HB808/2026, https://legiscan.com/MD/bill/SB490/2026
[13] https://legiscan.com/MA/text/H1128/2025
[14] https://legiscan.com/MN/text/HF3444/2025
[15] https://legiscan.com/NJ/text/S2918/2026
[16] https://legiscan.com/NM/text/SB20/2026
[17] https://legiscan.com/NY/text/A07522/2025, https://legiscan.com/NY/text/S04867/2025

Analytic Approach and Assumptions

Analytic Approach and Assumptions: Language Interpretation

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 1970, unless otherwise specifically mentioned.

CHBRP made the following assumptions based on the language of AB 1970:

- AB 1970 prohibits step therapy for drugs used to treat SMI and SUDs.
- Because SMI is defined as occurring in adults, CHBRP assumes the bill does not include serious emotional disturbance (SED) for children.[18]
- Because the bill focuses on step therapy, CHBRP limited its analysis to drugs that may be subject to step therapy requirements (i.e., newer, more expensive drugs such as atypical antipsychotics and LAIs) rather than all drugs that might be used to treat SMI or SUDs. Table 1 below shows the list of drugs that CHBRP considered in its analyses based on responses to its survey of the largest (by enrollment) providers of health insurance in California. The carriers indicated that step therapy requirements affect classes of SMI and SUD drugs in which multiple, effective generic drugs are available.
- Although the SUD definition includes tobacco use disorder, CHBRP did not include drugs to treat this in the analysis because those drugs are seldom subject to step therapy requirements.[19]

Table 1. Categories and Medications Included in CHBRP AB 1970 Analysis

Category	Generic Name	Drug (Branded)	Included in AB 1970 Analysis*
Substance use disorder (SUD)			
	buprenorphine HCl/naloxone HCl	Suboxone	Yes
	buprenorphine ER	Sublocade	Yes
	naltrexone ER	Vivitrol	Yes
	buprenorphine extended release	Brixadi	
	naltrexone oral		
	disulfiram		
	acamprosate		
Serious mental illness (SMI)			
Atypical (second-generation) antipsychotic (oral)	brexpiprazole	Rexulti	Yes

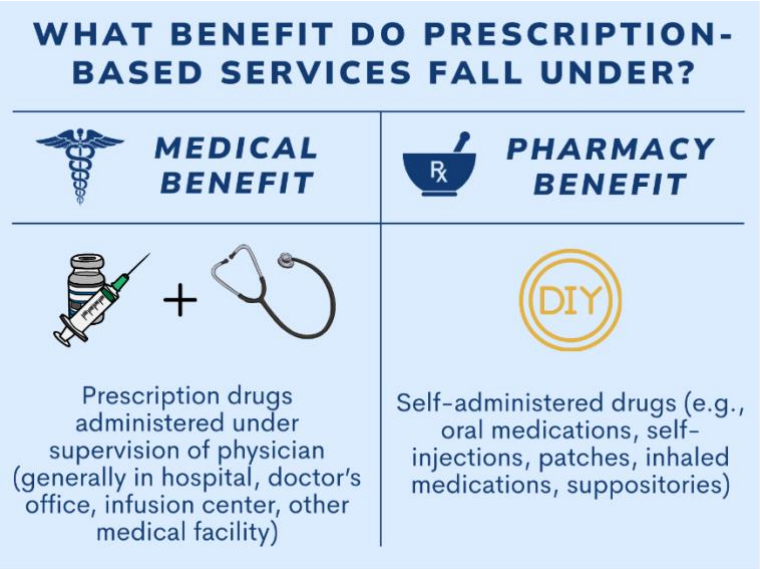
[18] An SED designation does not automatically become an SMI determination when a person turns 18.
[19] This is due to two reasons: (1) under the ACA, most private health plans and Medicaid expansion programs must cover tobacco cessation interventions as a "Grade A" preventive service, and (2) federal guidance specifies that to comply with these requirements, plans should not require PA or step therapy for the seven FDA-approved tobacco cessation medications.

Category	Generic Name	Drug (Branded)	Included in AB 1970 Analysis*
	cariprazine	Vraylar	Yes
	lumateperone	Caplyta	Yes
	olanzapine/samidorphan	Lybalvi	Yes
	iloperazone	Fanapt	Yes
	xanomeline/trospium chloride	Cobenfy	Yes
	aripiprazole		
	risperidone		
	paliperidone		
	olanzapine		
	quetiapine		
	clozapine		
	ziprasidone		
	lurasidone		
	asenapine		
First-generation antipsychotic (oral)	haloperidol		
	fluphenazine		
	chlorpromazine		
	perphenazine		
	thiothixene		
Long-acting injectable (LAI) antipsychotic	aripiprazole ER	Abilify Maintena	
	aripiprazole	Abilify Asimtufii	
	aripiprazole lauroxil	Aristada	Yes
	paliperidone palmitate	Invega	Yes
	risperidone	Perseris	
	risperidone	Uzedy	
Mood stabilizers (oral)	lithium		
	valproate/divalproex		

Category	Generic Name	Drug (Branded)	Included in AB 1970 Analysis*
	lamotrigine		
	carbamazepine		
	oxcarbazepine		
Antidepressants: SSRIs (oral)	sertraline		
	fluoxetine		
	paroxetine		
	citalopram		
	escitalopram		
	fluvoxamine ER		
Antidepressants: SNRIs (oral)	venlafaxine		
	desvenlafaxine		
	duloxetine		
	milnacipran		
	levomilnacipran	Fetzima	
Atypical antidepressant (oral)	vortioxetine	Trintellix	Yes
	vilazodone	Viibryd	Yes
	trazodone		
	mirtazapine		
	bupropion		

Source: California Health Benefits Review Program, 2026.
Note: *Drugs were chosen for inclusion in this analysis of AB 1970 based on CHBRP's survey of carriers.
Key: ER = extended release; HCl = hydrochloride; SNRI = serotonin and norepinephrine reuptake inhibitors; SSRI = selective serotonin reuptake inhibitors.

Pharmacy and Medical 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.[20] Their pharmacy benefit is "carved out" of the coverage provided by Medi-Cal managed care plans, so AB 1970 would not be expected to impact their benefit coverage.
- For this analysis, CHBRP has assumed that mandates that reference plans and policies that cover prescription drugs can be relevant to pharmacy benefit coverage or medical benefit coverage. Pharmacy benefits cover outpatient prescription drugs by covering prescriptions that are generally filled at a retail pharmacy, a mail-order pharmacy, or a specialty pharmacy.[21] Drugs that are physician-ordered and administered under the supervision of a physician (generally in a hospital, a provider's office, infusion center, or similar medical facility), along with the hospital stay or office visit, are generally covered through a medical benefit.

Cost-Related Analytical Approach and Assumptions

This analysis reports the estimated incremental impact of full-scale implementation of AB 1970 on benefit coverage, utilization, and cost for a single year.[22] Full-scale implementation typically requires an initial "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 1970. 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 1970, 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]

Approach and Assumptions on Baseline Coverage and Utilization

CHBRP used responses from its carrier survey to assess baseline step therapy requirements for SMI and SUD prescription drugs. CHBRP analyzed Milliman's proprietary 2024 Consolidated Health Cost Guidelines™ Sources Database (CHSD) to establish baseline utilization of branded and generic SMI and SUD prescription drugs.

Table 1 lists the SMI and SUD drugs appearing on at least one step therapy protocol per CHBRP's carrier survey, and are therefore included in this analysis. None of the plans and policies reported step therapy for LAI antipsychotics, which are covered under the medical benefit (see below). Drugs found to be subject to step therapy tend to be branded, newer oral agents, and per the *Medical Effectiveness* section in CHBRP's Technical Brief on AB 1970 and CHBRP's content expert,[24]

[20] 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*.
[21] See CHBRP's analysis of SB 853 (2022) for more details.
[22] 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.
[23] 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.
[24] Personal communication, Dr. Bowen Chung, March 12, 2026.

these offer no significant clinical advantage over existing generics, thus no offsets (e.g., to hospitalizations, ED visits, outpatient services) were modeled.

Assumptions

- FDA-labeled indications for virtually all LAIs require that a patient demonstrate tolerability on an oral formulation of the same medication prior to initiating the injectable form. Under the bill's exception for FDA-mandated sequencing, this clinical requirement would remain in effect regardless of the mandate.
- Medi-Cal pharmacy drug coverage is administered through Medi-Cal Rx, which does not impose step therapy requirements, but may require an alternative drug has been "considered or tried." As a result, no change in utilization or cost is expected for Medi-Cal managed care enrollees, and they are excluded from cost estimates. Medi-Cal managed care enrollees are included in the total population subject to the mandate but excluded from the cost and premium calculations.

Approach and Assumptions on Postmandate Coverage and Utilization

- To estimate the impact of the mandate on utilization of drugs currently subject to step therapy protocols, CHBRP assumes a 1% increase in utilization among enrollees in plans or policies with step therapy at baseline.[25] This assumption is derived from the broader PA literature but calibrated downward to reflect the narrower scope of step therapy relative to PA more generally. Busch and McCarthy (2025) estimate that eliminating PA would increase utilization of affected drugs by about 3%. CHBRP treats this 3% as a ceiling or maximum level of increase in utilization, since step therapy is only one component of the broader utilization management — which also includes PA — and a prohibition on just step therapy leaves other utilization management tools intact. Enrollees in plans or policies without step therapy at baseline would not experience any increase in utilization as a result of the mandate. CHBRP notes that plans and policies may respond to the removal of step therapy by strengthening other utilization management mechanisms, such as PA requirements or nonpreferred formulary placement, for the drugs affected by the mandate. To the extent that plans offset the removal of step therapy with other access controls, the actual increase in utilization of branded SMI and SUD prescription drugs could be lower than the 1% assumed here. As stated above, SB 306, effective July 1, 2026, requires plans and insurers to cease requiring PA for the most frequently approved covered health care services (those approved of 90% or more).
- CHBRP assumes the removal of step therapy results in *substitution* towards branded drugs instead of generic equivalents and no increase stemming from new users (i.e., persons not previously treated with any drug). CHBRP applies a decrease in generic drug utilization proportional to the projected increase in branded drug utilization, so that total drug utilization across the population affected by the mandate remains constant at baseline and postmandate.
- As noted in the *Background* section in CHBRP's Technical Brief on AB 1970, access barriers for the populations most likely to benefit from the use of SUD and SMI medications, including persons who are unhoused or have limited provider contact, are driven primarily by system-level factors such as provider and clinic capacity, the clinical requirement to demonstrate oral tolerability prior to initiating a long-acting injectable, and logistical barriers to daily oral medication adherence. These barriers exist independent of any plan-imposed step therapy and would not be affected by AB 1970.

For further details on data sources, methods, and assumptions, please see the *Cost Impact Analysis: Data Sources, Caveats, and Assumptions* in CHBRP's Technical Brief on AB 1970.

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[25] Corroborated by CHBRP's content expert, Dr Bowen Chung, March 12, 2026.

AB 1970 Impacts: Benefit Coverage and Cost

Benefit Coverage

CHBRP estimates that at baseline, 22,842,000 enrollees have state-regulated insurance subject to the mandate. CHBRP finds 72% or 16,439,000 are enrolled in plans or policies in compliance with AB 1970. CHBRP found the majority of plans and policies do not currently have step therapy in place for drugs used to treat SMI and SUDs (see Table 2).

Postmandate, CHBRP estimates 22,842,000 Californians would have coverage compliant with AB 1970. 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 7 in the Appendix.

Utilization and Unit Cost

Table 2 provides estimates of the impacts of AB 1970 on utilization and unit cost for SMI and SUD prescription drugs. CHBRP estimates that approximately 668,000 commercially insured adults have SMI and 1,781,000 have an SUD, with no change in enrollees diagnosed with these conditions postmandate. While 2.13% of Californians have both SMI and an SUD, this analysis examines them separately.

The estimated change in utilization of SMI and SUD prescription drugs is small. At baseline, approximately 26,000 enrollees are using SMI or SUD prescription drugs currently *subject to step therapy requirements*, representing a small fraction (7%) of the approximately 384,000 enrollees using generic SMI or SUD prescription drugs not subject to step therapy. Postmandate, CHBRP projects a net increase of approximately 300 enrollees accessing drugs currently subject to step therapy, with a corresponding decrease of 300 enrollees using only generic prescription drugs. Similarly, prescription fills for drugs currently subject to step therapy are estimated to increase by approximately 2,000, with a corresponding decrease of 2,000 fills for generic prescription drugs.

The large difference in average per-prescription cost between drugs subject to step therapy ($1,100) and those not subject to step therapy ($20) reflects the mix of drugs in each category: the former consists primarily of newer branded atypical antipsychotics and antidepressants, while the latter consists primarily of widely available generics such as sertraline, fluoxetine, and aripiprazole, which have very low per-unit costs. CHBRP assumes unit costs of individual drugs are unchanged. For this analysis, unit cost changes because the mix of drugs used will change.

Table 2. Impacts of AB 1970 on Utilization and Unit Cost, 2027

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Enrollees with SMI or SUD				
Number of enrollees with SMI	668,000	668,000	0	0%
Number of enrollees with SUD	1,781,000	1,781,000	0	0%
Utilization				
Number of enrollees with SMI or SUD accessing prescription drugs currently subject to step therapy requirements	26,000	26,300	300	1.15%
Number of enrollees with SMI or SUD accessing prescription drugs **not** currently subject to step therapy requirements	384,000	383,700	-300	-0.08%
Number of prescription fills for SMI/SUD-related prescription drugs currently subject to step therapy requirements	211,000	213,000	2,000	0.95%
Number of prescription fills for SMI/SUD-related prescription drugs **not** currently subject to step therapy requirements	1,749,000	1,747,000	-2,000	-0.11%
Unit cost				
Average cost to insurers per SMI/SUD-related prescription for prescription drugs currently subject to step therapy requirements (a)	$1,100	$1,100	$0	0%
Average cost to insurers per SMI/SUD-related prescription for prescription drugs **not** currently subject to step therapy requirements (b)	$20	$20	$0	0%

Source: California Health Benefits Review Program, 2026.
Notes: (a) within this average, unit costs range from $275 to $2750; (b) within this average, unit costs range from $10 to $350.
Key: SMI = serious mental illness; SUD = substance use disorder.

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,[26] and (2) those who pay for the benefit but do not utilize it. Enrollees who use a benefit may be responsible for

[26] 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.

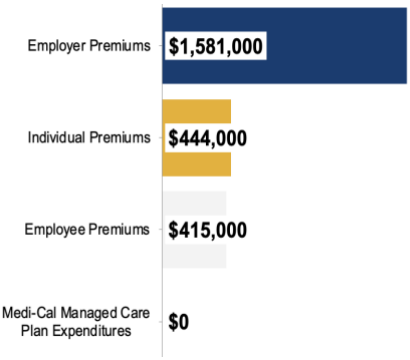
paying premiums and any out-of-pocket expenses related to the benefit. All enrollees within a risk pool share in these costs through the benefit's impact on plan premiums.

Expenditure Impacts on Employers and All Enrollees

As shown in Figure 2, for DMHC-regulated plans and CDI-regulated policies, AB 1970 would increase total premiums paid by employers and enrollees for newly covered benefits by approximately $2,440,000. This estimate reflects the cost differential between branded SMI/SUD drugs and generic equivalents for the small share of enrollees projected to transition from generics to branded drugs. For more details, see Table 7 in the Appendix. Enrollee premiums include premiums for those enrollees using the benefit in addition to those not using the benefit. Medi-Cal premium expenditures would not change because Medi-Cal Rx does not impose step therapy and is therefore not affected by the mandate.

Changes in premiums as a result of AB 1970 are small across market segments, and they vary somewhat by market segment (Table 3; see also Table 8 and Table 9 in Appendix).

Figure 2. Expenditure Impacts of AB 1970 on Employers and Enrollees



Source: California Health Benefits Review Program, 2026.

Table 3. Premium Impact Ranges of AB 1970 by Market Segment

Market Segment	Premium Impact Range (PMPM)
Commercial plans/policies	$0.014 - $0.016
Covered California – individually purchased	$0.015 - $0.017
CalPERS	$0.012
Medi-Cal	$0

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

Below, Table 4 provides estimates of the aggregate impacts of AB 1970 on premiums.

Table 4. Impacts of AB 1970 on Premiums, 2027

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Non-enrollee premiums				
Employer-sponsored (a)	$75,730,916,000	$75,732,381,000	$1,465,000	0.0019%
CalPERS employer (b)	$8,611,855,000	$8,611,971,000	$116,000	0.0013%
Medi-Cal (c)	$42,982,384,000	$42,982,384,000	$0	0.0000%

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Enrollee premiums				
Enrollees, individually purchased insurance	$25,775,325,000	$25,775,769,000	$444,000	0.0017%
Outside Covered California	$9,551,761,000	$9,551,929,000	$168,000	0.0018%
Through Covered California	$16,223,564,000	$16,223,840,000	$276,000	0.0017%
Enrollees, group insurance (d)	$21,828,135,000	$21,828,550,000	$415,000	0.0019%
Total premiums	$174,928,615,000	$174,931,055,000	$2,440,000	0.0014%

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.[27] 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 and Non-Users

AB 1970 would increase cost sharing a total of $158,000 for a small number of enrollees who transition from generic to branded SMI or SUD prescription drugs as a result of step therapy removal (Table 9). Because branded prescription drugs carry higher cost-sharing obligations than generics — reflecting higher allowed costs — affected enrollees would experience an increase in out-of-pocket expenses (Table 5). The impact of AB 1970 on average enrollee out-of-pocket expenses for those enrollees not utilizing the benefit is limited to the premium impact, as non-users would experience no change in cost sharing or expenses for noncovered benefits (Table 6).

For enrollees in plans that do not currently impose step therapy, CHBRP projects no change in out-of-pocket expenses. CHBRP projects the amount of copay or coinsurance per drug remains unchanged, but if people switch to higher-cost prescription drugs, their out-of-pocket expenses go up.

AB 1970–related changes in cost sharing for covered benefits (deductibles, copays, etc.) and out-of-pocket expenses for noncovered benefits are related to the number of enrollees with health insurance that would be subject to AB 1970 and expected to use the relevant treatments during the year after enactment (see Table 8 and Table 9). These changes would vary by market segment.

The presence of a deductible not yet met for the year[28] could result in the enrollee paying the full cost of the branded prescription drug, but reaching the annual out-of-pocket maximum[29] would result in the enrollee having no further cost sharing.

[27] For more detail, see CHBRP's resource *Pharmacy Benefit Coverage in State-Regulated Health Insurance*.
[28] For estimates of enrollees in plans and policies with deductibles, see CHBRP's resource *Deductibles in State-Regulated Health Insurance*.
[29] 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.

Table 5. Impact of AB 1970 on Average User Enrollee Expenses

	Large Group	Small Group	Individual	CalPERS	Medi-Cal
% of population with enrollee expenses impact due to AB 1970	0.002%	0.002%	0.002%	0.002%	0.000%
Avg. annual enrollee premium impact for users	$0.031	$0.063	$0.178	$0.023	$0.000
Avg. annual enrollee expenses impact for users (a)	$560	$660	$700	$550	$0

Source: California Health Benefits Review Program, 2026.
Notes: Average enrollee expenses includes cost sharing (e.g., deductibles, copays) for covered benefits and out-of-pocket expenses for noncovered benefits. Average annual enrollee premium impact includes the employee portion of the premium only.
(a) Benefit coverage for Medi-Cal beneficiaries does not generally include any cost sharing.

Table 6. Impact of AB 1970 on Average Non-User Enrollee Expenses

	Large Group	Small Group	Individual	CalPERS	Medi-Cal
% of Population without Enrollee Expenses Impact due to AB 1970	99.998%	99.998%	99.998%	99.998%	100.000%
Avg. Annual Enrollee Premium Impact for Non-Users	$0.031	$0.063	$0.178	$0.023	$0.000
Avg. Annual Enrollee Expenses Impact for Non-Users (a)	$0	$0	$0	$0	$0

Source: California Health Benefits Review Program, 2026.
Notes: Average enrollee expenses includes cost sharing (e.g., deductibles, copays) for covered benefits and out-of-pocket expenses for noncovered benefits. Average annual enrollee premium impact includes the employee portion of the premium only.
(a) Benefit coverage for Medi-Cal beneficiaries does not generally include any cost sharing.

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AB 1970 Impacts: Public Health

The public health impact analysis includes estimated impacts at baseline and postmandate. This section estimates the impact of AB 1970 on SMI and SUD outcomes, treatment utilization and costs, potential treatment harms, and potential disparities. See *Long-Term Impacts* for discussion of social drivers of health, premature death, and economic loss.

Estimated Public Health Outcomes

As presented in *AB 1970 Impacts: Benefit Coverage and Cost* section, an estimated 300 enrollees with SMI or SUD would newly utilize drugs currently subject to step therapy requirements each year, with a corresponding decrease of 300 enrollees using only generic drugs. The average annual enrollee expense impact for these users varies by market segment and is estimated to range from $0 (Medi-Cal enrollees) to $700 in the individual market (Table 5).

Measurable health outcomes relevant to AB 1970 include mental health crises, overdoses, symptom severity, and relapse, as well as utilization of health care services such as prescription drug use, outpatient visits, ED visits, and hospitalization. As presented in the *Medical Effectiveness* section in CHBRP's Technical Brief on AB 1970, CHBRP found:

- *Some evidence* that step therapy requirements for prescription drugs used to treat SMI decrease utilization of these drugs and increase hospitalizations.
- No direct evidence on the effect of step therapy requirements for prescription drugs used to treat SMI on health outcomes.
- The association between step therapy and increases in hospitalizations provides indirect evidence that step therapy is associated with increased severity of SMI symptoms.
- No studies identified regarding the effects of step therapy requirements for prescription drugs used to treat SUDs.
- *Some evidence* branded atypical antipsychotics are less effective than generic atypical antipsychotics at reducing symptoms related to bipolar disorder.
- *Some evidence* that branded atypical antipsychotics are less effective than generic atypical antipsychotics at reducing overall, positive, and negative symptoms of schizophrenia; reducing depression symptoms; and improving social functioning among persons with schizophrenia.
- No studies identified regarding the comparative effectiveness of prescription drugs used to treat SUDs.
- *Some evidence* that there is no difference between vortioxetine (branded) and generic SNRIs or generic SSRIs on symptom reduction among adults with major depressive disorder.
- Mixed findings regarding the harms of branded versus generic atypical antipsychotics and branded versus generic antidepressants.

Drugs found to be subject to step therapy tend to be branded, newer oral agents, and per the *Medical Effectiveness* section in CHBRP's Technical Brief on AB 1970 and CHBRP's content expert,[30] these offer no significant clinical advantage over existing generics, thus no offsets (e.g., to hospitalizations, ED visits, outpatient services) were modeled. In the case of AB 1970, there is *some evidence* to suggest that a shift from generic to branded atypical antipsychotics could result in lower risk of anticholinergic side effects and *some evidence* to suggest that a shift from generic SNRIs to vortioxetine (a branded antidepressant) could result in a lower risk of discontinuation due to adverse events. While it is estimated that 300 enrollees will shift from generic to branded drugs to treat SMI and SUDs each year, the comparative effectiveness literature for the drugs most likely to be shifted suggests that the branded drugs are not more effective than

[30] Personal communication, Dr. Bowen Chung, March 12, 2026

the generic drugs. Evidence regarding the harms of branded versus generic drugs is inconsistent across comparisons. Therefore, there is *conflicting evidence* of the impact on public health outcomes.

In the first year postmandate, CHBRP estimates a shift in utilization of drugs used to treat SMI and SUDs from generic to branded for 300 enrollees. It is not expected that this shift would have an impact on public health outcomes.

Potential Harms From AB 1970

When data are available, CHBRP estimates the marginal change in relevant harms associated with interventions affected by the proposed mandate. Step therapy curtails costs by requiring cheaper medical treatments first. There is potential harm in changing treatment plans for individuals with SMI and SUD. There are also potential harms in removing step therapy when the steps outlined are guided by evidence-based consensus treatment guidelines. However, CHBRP did not find medical effectiveness literature reviewing the extent of the impact of step therapy removal on SMI and SUD treatment plans. Therefore, CHBRP is not able to project if AB 1970 would result in any harms.

Impact on Disparities[31]

Disparities in SMI and SUD outcomes and care access exist by race and ethnicity, age, sex and gender, gender identity and sexual orientation, income, and geography. More information on disparities in SMI and SUD outcomes can be found in the *Background* section in CHBRP's Technical Brief on AB 1970. CHBRP estimates AB 1970 would not change disparities postmandate.

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

AB 1970 Impacts: Long-Term

In this section, CHBRP estimates the long-term impact of AB 1970, which CHBRP defines as impacts occurring after legislation is fully implemented.[32] 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

As noted in the preceding section, the immediate utilization impact of AB 1970 is projected to be a small shift from generic to branded SMI and SUD prescription drugs among a narrow subset of affected enrollees. Over the longer term, new branded SMI and SUD prescription drugs may appear in the market, potentially changing the number of patients using branded drugs.

Cost Impacts

If there is greater branded drug use over time in the long-term beyond the scope of this analysis, per-member costs could rise. If generic versions of currently branded SMI and SUD prescription drugs enter the market, downward pressure on drug prices would dampen projected cost increases, potentially reducing per-member costs over time.

Long-Term Public Health Impacts

Long-term public health impacts include implications on patient-provider relationships and the health care workforce, as well as on disparities and premature death.

Patient and Provider Relationship

A 2018 analysis described ethical concerns related to step therapy, such as lack of transparency in step therapy requirements and challenges for providers in tailoring treatment plans to their patients, which have longer-term public health implications including erosion of patient-provider relationships and trust in the health care system generally (Hoffman, 2018). By contrast, another study found that most physicians reported step therapy as having the potential to improve quality of medication use and make medications more affordable for patients (Fischer et al., 2019).

Health Care Workforce

The additional administrative burden of step therapy and impacts on providers' morale can lead to increased provider burnout, which has short- and long-term implications for the health care workforce. A survey of physicians found that although they report that step therapy has the potential to improve affordability of medications, it is implemented "inflexibly and inefficiently" (Lenahan et al., 2021). This sentiment among providers can exacerbate inequities if step therapy disincentivizes them from working in under-resourced settings including rural contexts and health care systems that primarily serve low-income and higher-need patient populations where clinicians have the primary responsibility of completing the step therapy administrative paperwork (Karmarkar et al., 2021; Sachs and Kyle, 2023). AB 1970 may lead

[32] 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 1970. 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 1970, 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.

to reduced provider burnout; however, step therapy is only one form of utilization management, and additional administrative burdens would remain.

Impacts on Disparities and the Social Drivers of Health[33]

In the case of AB 1970, evidence shows that although social drivers of health (SDOH) exist and contribute to SMI and SUD prevalence and access to care, CHBRP projects no changes in SDOH that would be attributable to AB 1970.

Taken as a whole, treatment of SMI and SUDs is inextricably linked bidirectionally with multiple important SDOH. Namely, SDOH such as the quality of a person's local built environment, proximity to violence, and socio-economic opportunities can influence a person's risk for SMI and SUD (Lin et al., 2024). Conversely, SMI and SUDs can influence a person's access to and experience with SDOH through the consequences of their disorder, such as involvement with the criminal legal system, job loss, unstable housing or family situations, and discrimination (Krebs et al., 2016).

Impacts on Premature Death

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, n.d.).

Individuals with SMI and SUD face significantly elevated risk of suicide ideation, attempts, and mortality. A recent study found that individuals with comorbid AUD with major depressive episode (MDE) and drug use disorder with MDE were 9 and 16 times more likely to have 12-month suicide ideation, respectively, than individuals without either MDE or SUD (Onaemo et al., 2022). CHBRP found *conflicting evidence* that step therapy is associated with increased severity of SMI symptoms such as suicidal ideation, attempts, and deaths.

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

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Appendix. Impacts of AB 1970 on Benefit Coverage and Expenditures, 2027

Table 7. Impacts of AB 1970 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%
Total enrollees with health insurance subject to AB 1970	22,842,000	22,842,000	0	0%
Total enrollees with health insurance affected by AB 1970	13,799,000	13,799,000	0	0%
Percentage of enrollees with coverage for mandated benefit	72%	100%	28%	38.95%
Number of enrollees with fully compliant coverage for mandated benefit	16,439,000	22,842,000	6,403,000	38.95%

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.[34]
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; DMHC = Department of Managed Health Care.

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

Table 8. 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 (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 1970	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
Premium Costs										
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.[35] CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).
(c) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans. Includes those who are also Medicare beneficiaries.
(d) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.[36]
(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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[35] For more detail, see CHBRP's resource *Pharmacy Benefit Coverage in State-Regulated Health Insurance*.
[36] For more detail, see CHBRP's resource *Sources of Health Insurance in California*.

Table 9. 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 1970	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
Premium costs (postmandate change										
Average portion of premium paid by employer (e)	$0.0120	$0.0108	$0.0000	$0.0103	$0.0000	$0.0000	$0.0111	$0.0109	$0.0000	$1,581,000
Average portion of premium paid by enrollee	$0.0026	$0.0053	$0.0148	$0.0020	$0.0000	$0.0000	$0.0026	$0.0046	$0.0173	$858,000
Total premium	$0.015	$0.016	$0.015	$0.012	$0.000	$0.000	$0.014	$0.016	$0.017	**$2,439,000**
Enrollee expenses (postmandate change)										
Cost sharing for covered benefits (deductibles, copays, etc.)	$0.0009	$0.0011	$0.0012	$0.0007	$0.0000	$0.0000	$0.0009	$0.0011	$0.0011	$158,000
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	$0.0155	$0.0172	$0.0160	$0.0130	$0.0000	$0.0000	$0.0146	$0.0167	$0.0184	**$2,597,000**
Postmandate percent change										
% change insured premiums	0.0019%	0.0020%	0.0017%	0.0013%	0.0000%	0.0000%	0.0014%	0.0019%	0.0021%	0.0014%
% change total expenditures	0.0019%	0.0017%	0.0014%	0.0013%	0.0000%	0.0000%	0.0013%	0.0016%	0.0018%	0.0013%

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.[37] 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).
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(d) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.[38]
(e) In some cases, a union or other organization, or Medi-Cal for its beneficiaries.
(f) Includes only those expenses that are paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that will be newly covered postmandate. Other components of expenditures in this table include all health care services covered by insurance.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care.

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

CHBRP Committees and Staff

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.

For more information about CHBRP's methods and approach, please visit our website.

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