Date of Hearing: April 29, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 1429 (Bains) – As Amended April 2, 2025

SUBJECT: Behavioral health reimbursement.

SUMMARY: Requires, on or after May 1, 2022, the Kaiser Foundation Health Plan (Kaiser) to fully reimburse an enrollee who incurs out-of-pocket costs for behavioral health care services or mental health prescription medication obtained from non-Kaiser providers, facilities, or pharmacies until the Department of Managed Health Care (DMHC) certifies to the Legislature that Kaiser has successfully completed implementation of the corrective action work plan (CAWP) resulting from its 2023 settlement agreement with DMHC. Specifically, **this bill**:

1) Requires, on or after May 1, 2022, Kaiser to fully reimburse an enrollee who incurs out-of-pocket costs for behavioral health care services or mental health prescription medication obtained from non-Kaiser providers, facilities, or pharmacies until DMHC certifies to the Legislature that Kaiser has successfully completed implementation of the CAWP resulting from its 2023 settlement agreement with DMHC.

2) Requires reimbursement to be provided within 60 days of an enrollee's submission of documented expenses.

3) Requires an enrollee to submit all of the following in order to receive reimbursement:

    a) Receipts or invoices showing actual costs paid;

    b) Documentation that the service or medication was prescribed or recommended by a licensed mental health provider; and,

    c) A signed statement affirming that the expense was incurred due to the enrollee's inability to obtain timely and appropriate care through Kaiser.

4) Requires Kaiser, if they fail to provide reimbursement, to pay the original amount plus 10% per annum interest to the enrollee and a $5,000 fine per incident.

5) Requires Kaiser to establish procedures for all of the following actions:

    a) Enrollee submission of reimbursement requests in either online or paper form;

    b) Kaiser's processing of reimbursement requests;

    c) Appeals of denied reimbursement requests in either online or paper form; and,

    d) Statistical monitoring of submitted, approved, and denied reimbursement requests.

6) Requires DMHC to review and determine if Kaiser has fulfilled the requirements in 4) above.

7) Requires Kaiser to submit a monthly report to DMHC that includes:

a) The number of reimbursement requests received;

b) Total amount reimbursed;

c) Average processing time for reimbursement requests; and,

d) Number of denied reimbursement requests and reasons for denial.

8) Defines "behavioral health care" as behavioral health services, psychiatric services, psychological services, counseling, addiction services, and related prescription medications that are offered by Kaiser.

9) Defines "out-of-pocket costs" as any expenses paid directly by an enrollee, including:

a) Copayments;

b) Deductibles;

c) Prescription medication costs;

d) Provider visit fees;

e) Telehealth consultation fees; and,

f) Transportation costs directly related to obtaining behavioral health care.

EXISTING LAW:

1) Establishes the DMHC to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975. [Health and Safety Code (HSC) § 1340, *et seq*.]

2) Requires health plans to meet specified requirements regarding facilities, personnel, equipment, and services as a condition of licensure. [HSC § 1367]

3) Establishes California's Essential Health Benefits (EHBs) benchmark under the Patient Protection and Affordable Care Act (ACA) as the Kaiser Small Group Health Maintenance Organization. Establishes existing California health insurance mandates and the 10 ACA mandated benefits, including mental health and substance use disorder coverage. [HSC § 1367.005]

4) Requires every health plan that provides hospital, medical, or surgical coverage to provide coverage for medically necessary treatment of mental health and substance use disorders, under the same terms and conditions applied to other medical conditions, as specified. [HSC § 1374.72]

5) Requires a health plan that provides hospital, medical, or surgical coverage to base any medical necessity determination or the utilization review criteria that the plan, and any entity acting on the plan's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders on current generally accepted standards of mental health and substance use disorder care, as specified. Requires a health plan or insurer to apply the criteria and guidelines set

forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty in conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders in children, adolescents, and adults. [HSC § 1374.721]

6) Requires health plans to ensure that all services be readily available at reasonable times to each enrollee consistent with good professional practice, and to the extent feasible, a health plan to make all services readily accessible to all enrollees consistent with existing law on timely access to health care services. [HSC § 1367]

7) Requires DMHC to develop and adopt regulations to ensure that enrollees have access to health care services in a timely manner, regarding:

   a) Waiting times for appointments, including primary and specialty care physicians;

   b) Care in an episode of illness, including timeliness of referrals and obtaining other services, as needed; and,

   c) Waiting time to speak to a physician, registered nurse, or other qualified health professional trained to screen or triage. [HSC § 1367.03]

8) Requires, in developing these standards, DMHC to consider the clinical appropriateness, the nature of the specialty, the urgency or care, and the requirements of law governing utilization review. [HSC § 1367.03]

9) Requires every plan to establish procedures in accordance with DMHC regulations for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities, and costs, as specified. [HSC § 1370]

10) Requires DMHC to conduct examinations of the fiscal and administrative affairs of any health plan, and each person with whom the plan has made arrangements for administrative, management, or financial services, as often as deemed necessary to protect the interest of subscribers or enrollees, but not less frequently than once every five years [HSC § 1382]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, this bill is a necessary response to Kaiser's persistent and systemic failure to provide timely and adequate behavioral health care to its enrollees, despite repeated citations, fines, and mandated corrective actions. The author states that Kaiser's integrated healthcare model, which combines insurance coverage and service delivery, creates significant barriers for patients seeking external care when Kaiser's services fall short. The author continues that enrollees often face lengthy delays, inadequate treatment options, and an inability to access out-of-network providers without incurring significant personal costs. The author argues that this bill addresses these injustices by requiring Kaiser to cover the full cost of out-of-network behavioral health services when it fails to meet state and federal standards. The author notes that by shifting the financial burden from patients to Kaiser, this bill provides immediate relief for those struggling to access critical mental health care and ensures that Kaiser is held accountable until it fully

complies with the law. The author concludes that legislation is essential to protecting patient rights and improving behavioral health outcomes across California.

2) **BACKGROUND.** Kaiser is the largest health plan in California with 9.4 million members across the state. Kaiser operates under an integrated care model, meaning their members primarily receive care at Kaiser Foundation Hospitals and through providers with two exclusively contracted medical groups, The Permanente Medical Group and Southern California Permanente Medical Group. Collectively the health plan, hospitals, and medical groups are referred to as "Kaiser Permanente."

   a) **Mental Health Parity.** Federal Mental Health Parity laws require if a health plan includes services for mental health and substance use disorders as part of their benefits that those services must be covered under the same terms and conditions as other medical services. The ACA also specifies coverage of the 10 EHBs, including mental health and substance use disorder treatment services. The ACA went beyond existing federal law by mandating coverage instead of requiring parity only if coverage is provided.

      SB 855 (Wiener), Chapter 151, Statutes of 2020, requires commercial health plans and insurers in California to provide full coverage for the treatment of all mental health conditions and substance use disorders. SB 855 also establishes specific standards for what constitutes medically necessary treatment and criteria for the use of clinical guidelines. SB 855 applies to all state-regulated health plans and insurers that provide hospital, medical, or surgical coverage, and to any entity acting on the plan or insurer's behalf. A health plan cannot limit benefits or coverage for mental health or substance use disorder treatments or services when medically necessary.

   b) **Timely access laws.** SB 221 (Wiener) Chapter 724, Statutes of 2021, codified DMHC regulations requiring health plans to meet a set of standards, including specific time frames under which enrollees must be able to access care. These requirements provide health plan members the right to behavioral health appointments within the following time frames:

      i) Urgent care without prior authorization: **within 48 hours**;

      ii) Urgent care with prior authorization: **within 96 hours**;

      iii) Non-urgent psychiatrist appointments **within 15 business days**, and non-physician mental health or substance use disorder providers **within 10 business days**; and,

      iv) Non-urgent follow-up appointments with a non-physician mental health care or substance use disorder provider **within 10 business days** of the prior appointment for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition.

   c) **History of behavioral health complaints against Kaiser.** DMHC is charged with enforcing behavioral health laws, including mental health parity and timely access laws. The National Union of Healthcare Workers (NUHW), sponsors of this bill, provided a timeline of complaints that NUHW has filed with DMHC, surveys and investigations that DMHC has conducted, and settlement agreements that DMHC has reached regarding Kaiser's delivery of behavioral health services. In November of 2011, NUHW therapists

filed their first complaint against Kaiser to DMHC, including a 34-page analysis of problems affecting Kaiser's behavioral health services. From 2011 to 2021, DMHC conducted various investigations and surveys of Kaiser, resulting in citations, fines, and settlements.

In May of 2022, DMHC announced that it was initiating a non-routine survey of Kaiser after receiving complaints from enrollees, providers, and other stakeholders concerning Kaiser's mental health and substance use disorder operations. Key issues included Kaiser's internal and external provider network, timely access to care, process for intake and follow-up appointments, appointment scheduling processes, levels of care and associated decision-making processes, medical record documentation and retention practices, and monitoring of urgent appointments. In August of 2022, DMHC launched an additional targeted enforcement investigation against Kaiser after receiving complaints that Kaiser was failing to schedule mental health appointments within the timely access standards set forth by state law.

In October of 2023, DMHC and Kaiser announced a $200 million settlement for both the enforcement investigation and non-routine survey. Collectively, the investigation and survey identified several violations and 20 deficiencies across Kaiser's plans. The settlement included $50 million in fines, a $150 million commitment to invest in programs that improve behavioral health services for all Californians beyond Kaiser's existing obligations, and a requirement that Kaiser take corrective action to address deficiencies in their delivery and oversight of behavioral health care to their members.

d) CAWP. The settlement agreement identified areas of concern with corresponding corrective action areas (CAAs). The agreement further stipulated that Kaiser would hire consultants to develop a CAWP to address the eight CAAs outlined in the agreement, which include:

i) Oversight;

ii) Access;

iii) Network and Referrals;

iv) Grievance and Appeals;

v) Future Strike Contingency;

vi) Mental Health Parity;

vii) Member Communications; and,

viii) Continuous Improvement and Comprehensive Review.

On August 15, 2024 Kaiser submitted their initial CAWP to DMHC. An updated version was released on March 12, 2025.

e) Claim reimbursement requirement. Under the third CAA, network and referrals, the settlement dictates that Kaiser is required to develop a process for identifying members who attempted, but were unable to, obtain timely and clinically appropriate behavioral

health care services in-network and, as a result self-referred to an out-of-network provider. The settlement further requires Kaiser to develop a process for evaluating enrollee out-of-network claims for reimbursement. The settlement states that the terms of such reimbursement will be subject to agreement between Kaiser and DMHC. This bill seeks to codify a claims reimbursement into state law.

3) **SUPPORT.** The National Union of Healthcare Workers (NUHW), sponsor of this bill, states that despite nearly two decades of escalating regulatory sanctions, Kaiser's behavioral health services remain sorely understaffed and frequently fail to provide access to timely and appropriate care. NUHW states that as a result, patients often experience lengthy delays in obtaining services, an overreliance on group therapies, and frustrating obstacles that push many to forgo care or seek treatment elsewhere at their own expense. NUHW continues that this bill ensures that Kaiser patients are not held hostage by a provider that has failed to deliver adequate care and consistently broken state behavioral health laws. NUHW argues that until Kaiser fully implements its CAWP, which DMHC expects to take up to five years, Kaiser patients will continue to suffer from lack of timely access to behavioral health services and a substandard grievance and appeals process. NUHW continues that this bill provides relief to Kaiser enrollees by requiring Kaiser to cover costs such as copayments, deductibles, prescription medication costs, provider visit fees, telehealth consultation fees, and transportation costs directly related to obtaining behavioral health care from non-Kaiser providers when Kaiser fails to provide timely and appropriate care, based solely upon the enrollees' written attestation to Kaiser's failure and submission of receipts and documentation that the services were prescribed or recommended by a licensed mental health provider. NUHW concludes that this bill ensures that Kaiser patients receive the behavioral health care they need and are entitled to under California law.

4) **OPPOSITION.** Kaiser Permanente is opposed to this bill, stating that it is unnecessary and generally duplicative of current law. Kaiser Permanente notes that this bill raises possible quality and patient safety concerns. Kaiser continues that while this bill resembles their settlement agreement and CAWP with the DMHC, the bill does not require their enrollees to attempt to access care within Kaiser Permanente’s network first before going outside of network. Kaiser Permanente states that this is inconsistent with current law and common practice in a managed care environment. Kaiser Permanente further states that this bill is costly, allowing providers and pharmacies to charge their members without limit since there is no agreed-upon rate. Kaiser Permanente argues that the bill is an “any willing provider or pharmacy” mandate which is counterproductive to access since it would undermine their ability to contract with external providers. Kaiser Permanente continues that under this bill, care would be provided outside the medical home, causing fragmentation and possible quality and patient safety issues, such as overprescribing of addictive, dangerous or scheduled drugs. Kaiser Permanente notes that the pharmacy component of this bill is also unnecessary and will be costly and difficult to administer, stating that medication access is not an issue or a noted deficiency for them.

5) **PREVIOUS LEGISLATION.**

   a) SB 221 (Wiener), Chapter 724, Statutes of 2021 codifies existing timely access to care standards for health plans and insurers, applies these requirements to Medi-Cal Managed Care plans, and adds a standard for non-urgent follow-up appointments for nonphysician

mental health care or substance use disorder providers that is within 10 business days of the prior appointment.

b) SB 855 (Wiener), Chapter 151, Statutes of 2020 revises and recasts California's Mental Health Parity provisions, and requires a health plan contract or disability insurance policy issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of mental health and substance use disorder, as defined, under the same terms and conditions applied to other medical conditions and prohibits a health plan or disability insurer from limiting benefits or coverage for mental health and substance use disorder to short-term or acute treatment. Specifies that if services for the medically necessary treatment of a mental health and substance use disorder are not available in network within the geographic and timely access standards in existing law, the health plan or insurer is required to arrange coverage to ensure the delivery of medically necessary out of network services and any medically necessary follow up services, as specified.

6) **PROPOSED AMENDMENT.** The committee may wish to make technical amendments to the definition of "Kaiser."

7) **POLICY COMMENT.** This bill aims to codify the claims reimbursement process, required under the DMHC/Kaiser settlement and CAWP, outside of an agreement between Kaiser and DMHC. In background provided to the committee, the author of this bill states that Kaiser's track record of underinvesting in mental health and repeated violations raises questions about the appropriateness of their oversight and administration of a program that would not be necessary had they been in compliance with the law.

   While there is merit in the author's goal for patient, provider, and legislator perspectives to be considered as the claims reimbursement process is established, there are concerns with pursing a legislative proposal that is likely to come into conflict with the process established through the CAWP.

   According to the timelines and detailed plans published in the CAWP, the claims reimbursement process is set to be completed in Q2 of 2025. If these timelines are met, the claims reimbursement process established between DMHC and Kaiser would be in effect and implemented well before the provisions of this bill. It is unclear how the terms of the process established through the CAWP and settlement agreement would interact with a new state law. Would one supersede the other? Or would they both exist, even if they are in conflict?

   DMHC and Kaiser may wish to work with the author and sponsors, to the extent possible, to find pathways for the Legislature and stakeholders to provide input on the pending claims reimbursement process being established through the CAWP to minimize consumer confusion and ensure a thorough, patient-centered process is implemented as swiftly as possible.

REGISTERED SUPPORT / OPPOSITION:

Support

National Union of Healthcare Workers (sponsor)

California Alliance for Retired Americans
California Alliance of Child and Family Services
California Federation of Labor Unions, AFL-CIO
California OneCare Education Fund
California Pan - Ethnic Health Network
County Behavioral Health Directors Association (CBHDA)
Courage California
Health Care for All - California
Healthy California Now
Mental Health America of California
National Association of Social Workers – California Chapter
Physicians for a National Health Program -- California Chapter
U.S. Pain Foundation
Unite Here International Union, AFL-CIO
Western Center on Law & Poverty

Opposition

Cal Asian Chamber of Commerce
California African American Chamber of Commerce
California Asian Pacific Chamber of Commerce
California Association of Health Plans
California Chamber of Commerce
California Hispanic Chambers of Commerce
California Medical Association (CMA)
Chino Valley Chamber of Commerce
Kaiser Permanente
Oakland Chamber of Commerce
Sacramento Hispanic Chamber of Commerce
Sacramento Metro Chamber of Commerce
Southwest California Legislative Council
The Greater Coachella Valley Chamber of Commerce
Tri County Chamber Alliance

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