Date of Hearing: March 24, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2011 (Hart) – As Introduced February 17, 2026

SUBJECT: Nonquantitative treatment limitations.

SUMMARY: Codifies federal Mental Health Parity and Addiction Equity Act (MHPAEA) regulations into state law. Specifically, **this bill**:

1) Requires any condition or procedure defined by a health plan contract or health insurance policy as being or as not being a medical condition or surgical procedure to be defined consistently with generally recognized independent standards of current medical practice. Permits, to the extent that generally recognized independent standards of current medical practice do not address whether a condition or procedure is a medical condition or surgical procedure, a health plan or insurer to define the condition or procedure in accordance with applicable federal and state law.

2) Requires any condition defined by a health plan contract or health insurance policy as being or as not being a mental health (MH) condition to be defined consistently with generally recognized independent standards of current medical practice. Requires, to be consistent with generally recognized independent standards of current medical practice, the definition to include all conditions covered under the health plan contract or health insurance policy, except for substance use disorders (SUDs) that fall under any of the diagnostic categories listed in the mental, behavioral, and neurodevelopmental disorders chapter of the most recent version of the International Classification of Diseases (ICD) or that are listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

3) Permits, to the extent that generally recognized independent standards of current medical practice do not address whether a condition is a MH condition, a health plan or insurer to define the condition in accordance with applicable federal and state law.

4) Requires any disorder defined by the health plan contract or health insurance policy as being or as not being a SUD to be defined consistently with generally recognized independent standards of current medical practice. Requires, to be consistent with generally recognized independent standards of current medical practice, the definition to include all covered disorders that fall under any of the diagnostic categories listed as a mental or behavioral disorder due to psychoactive substance use, or equivalent category, in the mental, behavioral, and neurodevelopmental disorders chapter, or equivalent chapter, of the most recent version of the ICD or that are listed as a substance-related and addictive disorder, or equivalent category, in the most recent version of the DSM.

5) Permits, to the extent that generally recognized independent standards of current medical practice do not address whether a disorder is a SUD, a health plan or insurer to define the disorder in accordance with applicable federal and state law.

6) Establishes a nonquantitative treatment limitation (NQTL) to include, but not be limited to, all of the following:

a) Medical management standards, including, for example, prior authorization, that limit or exclude benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;

b) Formulary design for prescription drugs;

c) For plans or insurers with multiple network tiers, network tier design;

d) Standards related to network composition, including, but not limited to, standards for provider and facility admission to participate in a network or for continued network participation, including methods for determining reimbursement rates, credentialing standards, and procedures for ensuring the network includes an adequate number of each category of provider and facility to provide services under the plan contract;

e) Plan or insurer methods for determining out-of-network rates, including, for example, allowed amounts; usual, customary, and reasonable charges; or application of other external benchmarks for out-of-network rates;

f) Refusal to pay for higher cost therapies until it can be shown that a lower cost therapy is not effective, also known as fail-first policies or step therapy protocols;

g) Exclusions based on failure to complete a course of treatment; and,

h) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan contract.

7) Prohibits, for purposes of determining comparability and stringency under this bill, a health plan or insurer from relying upon discriminatory factors or evidentiary standards to design an NQTL to be imposed on MH or SUD benefits. Requires a factor or evidentiary standard to be discriminatory if the information, evidence, sources, or standards are biased or not objective in a manner that discriminates against MH or SUD benefits as compared to medical/surgical benefits.

8) Requires information, evidence, sources, or standards to be considered biased or not objective in a manner that discriminates against MH or SUD benefits as compared to medical/surgical benefits if, based on all of the relevant facts and circumstances, the information, evidence, sources, or standards systematically disfavor access or are specifically designed to disfavor access to mental health or substance use disorder benefits as compared to medical/surgical benefits.

9) Defines relevant facts and circumstances as, but not limited to, all of the following:

a) The reliability of the source of the information, evidence, sources, or standards, including any underlying data;

b) The independence of the information, evidence, sources, and standards relied upon;

c) The analyses and methodologies employed to select the information and the consistency of their application; and,

d) Any known safeguards deployed to prevent reliance on skewed data or metrics.

10) Requires information, evidence, sources, or standards to not be considered biased or not objective if the health plan or insurer has taken the steps necessary to correct, cure, or supplement any information, evidence, sources, or standards that would have been biased or not objective in the absence of those steps.

11) Requires historical plan data or other historical information from a time when the health plan or insurer was not subject to, or not in compliance with, the MHPAEA to be considered biased or not objective, as specified.

12) Requires a health plan or health insurer to collect and evaluate relevant data in a manner reasonably designed to assess the impact of an NQTL on relevant outcomes related to access to MH and SUD benefits and medical/surgical benefits and carefully consider the impact as part of the plan's evaluation.

13) Prohibits a health plan or health insurer from disregarding relevant outcomes data that it knows, or reasonably should know, suggests that an NQTL is associated with material differences in access to MH or SUD benefits as compared to medical/surgical benefits. Permits the Department of Managed Health Care (DMHC) and California Department of Insurance (CDI) to specify the type, form, and manner of collection and evaluation for the data required under this bill.

14) Requires a health plan or health insurer that provides both medical/surgical benefits and MH or SUD benefits and that imposes any NQTLs on MH or SUD benefits to perform and document comparative analyses of the design and application of each NQTL applicable to MH or SUD disorder benefits. Specifies what must be included in the comparative analysis.

15) Requires the health plan or health insurer to make the comparative analysis available to DMHC and CDI on an annual basis commencing January 1, 2027. Requires the health plan or insurer to provide a copy of the comparative analysis when requested by any applicable state authority or an enrollee/insured or their authorized representative no later than 30 days after receiving a request. Prohibits a health plan or health insurer from withholding any information contained in the comparative analysis, including any information from or developed by third parties.

16) Requires, if DMHC or CDI makes a final determination of noncompliance, the health plan or health insurer to notify all enrollees that the plan has been determined to not be in compliance with the requirements of parity or this bill with respect to the plan contract, as specified.

17) Requires, if a health plan or health insurer receives a final determination from DMHC or CDI that the plan or insurer is not in compliance with the comparative analysis requirements or the requirements of the federal MHPAEA, the NQTL to be deemed a violation of parity. Permits, in addition to existing penalty authority, DMHC or CDI to direct the health plan or insurer not to impose the NQTL with respect to MH or SUD benefits in the relevant classification, unless and until the plan or insurer demonstrates compliance with the state or federal law or takes appropriate action to remedy the violation.

18) Defines "medical/surgical benefits" as benefits with respect to items or services for medical conditions or surgical procedures, as defined under the terms of the health plan contract or health insurance policy and in accordance with applicable federal and state law, but does not include MH benefits or SUD benefits.

19) Defines "MH benefits" as benefits with respect to items or services for MH conditions, as defined under the terms of the health plan contract or health insurance policy and in accordance with applicable federal and state law, but does not include medical/surgical benefits or SUD benefits.

20) Defines "SUD benefits" as benefits with respect to items or services for SUD, as defined under the terms of the health plan contract or health insurance policy and in accordance with applicable federal and state law, but does not include medical/surgical benefits or mental health benefits.

EXISTING LAW:

1) Establishes DMHC to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 and CDI to regulate health insurers. [Health and Safety Code (HSC) § 1340, *et seq*., and Insurance Code (INS) § 106, *et seq*.]

2) Establishes as California's Essential Health Benefits benchmark under the Patient Protection and Affordable Care Act (ACA), the Kaiser Small Group Health Maintenance Organization, existing California health insurance mandates, and the ten ACA mandated benefits. [HSC § 1367.005 and INS § 10112.27]

3) Defines "basic health care services" as all of the following:

   a) Physician services, including consultation and referral;

   b) Hospital inpatient services and ambulatory care services;

   c) Diagnostic laboratory and therapeutic radiologic services;

   d) Home health services;

   e) Preventive health services;

   f) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage. Basic health care services includes ambulance and ambulance transport services provided through the 911 emergency response system; and,

   g) Hospice care, as specified. [HSC § 1345]

4) Requires every disability insurance policy and health plan that provides hospital, medical, or surgical coverage to provide coverage for medically necessary treatment of MH and SUDs, under the same terms and conditions applied to other medical conditions, as specified. [HSC § 1374.72 and INS § 10144.5]

5) Defines medically necessary treatment of MH or SUD including that the service or product is in accordance with generally accepted standards of mental health or substance use disorder

care, clinically appropriate in terms of type, frequency, extent, site, and duration. [HSC § 1374.72 and INS § 10144.5]

6) Requires a health plan or insurer that provides hospital, medical, or surgical coverage to base any medical necessity determination or the utilization review criteria on current generally accepted standards of MH and SUD care, as specified. Requires medical necessity determinations concerning service intensity, level of care placement, continued stay, and transfer or discharge of enrollees diagnosed with MH and SUDs to be conducted in accordance with the requirements in 7) below. [HSC § 1374.72 and INS § 10144.5]

7) Requires a health plan or insurer 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 MH and SUDs on current generally accepted standards of MH and SUD 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 MH and SUDs in children, adolescents, and adults. [HSC § 1374.721 and INS § 10144.52]

8) Requires the criteria or guidelines used by health plans and insurers, or any entities with which plans or insurers contract for utilization review or utilization management functions, to determine whether to authorize, modify, or deny health care services to:

   a) Be developed with involvement from actively practicing health care providers;

   b) Be consistent with sound clinical principles and processes;

   c) Be evaluated, and updated if necessary, at least annually;

   d) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the enrollee or insured in that specified case; and,

   e) Be available to the public upon request. [HSC § 1363.5 and INS § 10123.135]

9) Requires every health plan to establish and maintain a grievance system approved by DMHC under which enrollees may submit grievances to the plan. Requires a plan's response to also comply with federal requirements. Requires, in regulations, that a plan's grievance system be established in writing and provide for procedures that will receive, review and resolve grievances within 30 calendar days of receipt by the plan, or any provider or entity with delegated authority to administer and resolve the plan's grievance system. Defines grievance as a written or oral expression of dissatisfaction regarding the plan and/or provider. [HSC § 1368]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, this bill addresses a serious risk patients face when seeking MH or SUD care. The author argues that access to care is at risk for millions of Californians because the Trump administration has recklessly decided to stop enforcing federal protections that require insurers provide equal access to MH care as they do with traditional medical treatment. The author continues that this bill will enshrine protections in state law, ensuring that state regulators can continue to enforce these parity requirements on insurers, regardless of the changes that occur at the federal level. The author concludes that at a time when our state is working to expand behavioral health, this bill ensures that the promise of equal access becomes a reality for Californians.

2) **BACKGROUND.**

   a) **MH Parity**. Federal MH 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 ten EHBs, including MH and SUD 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 MH conditions and SUDs. 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 MH or SUD treatments or services when medically necessary.

   b) **2024 MHPAEA Regulations**. In September 2024, the federal Departments of Labor, Health and Human Services, and Treasury released updated MHPAEA regulations to implement provisions of the Consolidated Appropriations Act of 2021 and update 2013 regulations that implemented the law. The final rule strengthens standards for demonstrating parity in coverage. It clarifies critical terminology, requires that NQTLs be comparable in both design and application between MH/SUD and medical/surgical benefits, prohibits the use discriminatory factors or standards that systematically disadvantage MH/SUD care, and mandates a data-drive comparative analysis to monitor compliance. In 2025, the ERISA Industry Committee (ERIC) filed a complaint against the federal government seeking to invalidate the 2024 rules, the federal administration subsequently announced that it would not enforce key requirements.

      In November 2025 the Association of California Life & Health Insurance Companies (ACLHIC) filed suit against CDI and the Insurance Commissioner, seeking to invalidate state regulations that incorporate the 2024 rule. The legal complaint relies heavily on the federal nonenforcement announcement. However, states, as the primary enforcers of health insurance standards, are still able to enforce the 2024 federal rule and additional protections in their respective laws. According to the Commonwealth Fund, a few states have moved to adopt the 2024 federal MHPAEA rule into state law. Washington enacted legislation that requires insurers to comply with the federal rule as published in 2024.

Colorado similarly leveraged the 2024 federal rule to add state protections through legislation. This bill similarly aims to codify the 2024 federal rule into California law to clarify its application and ensure it remains in place regardless of action at the federal level.

3) **SUPPORT.** The Kennedy Forum, Steinberg Institute, California State Association of Psychiatrists, and California Academy of Child & Adolescent Psychiatry are cosponsoring this bill. The sponsors state that in 2024, federal regulators issued final MHPAEA regulations that clarify how existing statutory parity obligations must be evaluated and enforced, including standards for demonstrating compliance both as written and in operation. The sponsors continue that these regulations did not create new parity requirements; rather, they provided needed clarity to support consistent enforcement of existing law. The sponsors argue that this bill codifies those federal standards into California statute to ensure continuity and enforceability, regardless of future federal administrative or judicial actions. The sponsors note that California has taken this approach before, including during the first Trump administration when the state codified key provisions of the ACA to protect Californians from federal rollbacks. The sponsors continue that this bill does not create new benefit mandates, expand coverage, or impose new obligations on state regulators. The sponsors state that DMHC and CDI are already enforcing parity consistent with these standards under existing authority and this bill simply affirms and preserves those practices in state law. The sponsors conclude that this bill reaffirms California's commitment to strong, enforceable parity protections and preserving the progress achieved.

4) **OPPOSITION.** The California Association of Health Plans and ACLHIC are opposed to this bill, stating that they have significant concerns that codifying the existing federal rule, which is currently under review, rather than adhering to longstanding statutory framework, would introduce legal and operational uncertainty. The opposition argues that this bill does not merely preserve parity; it goes beyond the existing federal and state standards and creates a separate and much more onerous structure. The opposition continues that this bill closely mirrors the federal MHPAEA Final Rules issued in September 2024, which, in May 2025, the U.S. Department of Justice announced that it would not enforce while the Administration considers whether to modify or rescind. The opposition argues that by embedding these requirements into state law now, this bill risks locking California carriers into conflicting and potentially irreconcilable obligations without clear evidence of improved access or quality for patients. The opposition believes there are more targeted, effective approaches California can pursue to expand access to MH/SUD services, such as investments that directly increase the availability of care, such as improving access to high-quality, affordable, and evidence-based behavioral health services for children and adolescents.

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 MH care or SUD providers that is within 10 business days of the prior appointment.

   b) SB 855 (Wiener) revises and recasts California's MH 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 MH and

SUD, 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 MH and SUD to short-term or acute treatment. Specifies that if services for the medically necessary treatment of a MH and SUD 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.

REGISTERED SUPPORT / OPPOSITION:

Support

California Academy of Child and Adolescent Psychiatry (sponsor)
California State Association of Psychiatrists (sponsor)
Steinberg Institute (sponsor)
The Kennedy Forum (sponsor)
Insurance Commissioner Ricardo Lara / California Department of Insurance (sponsor)
California Alliance of Child and Family Services
California Association of Alcohol and Drug Program Executives, Inc.
California Behavioral Health Association
California Chronic Care Coalition
California Coalition for Behavioral Health
California Psychological Association
Coalition for Developmental Approaches
County Behavioral Health Directors Association
Greenhouse Therapy Center
Inseparable
MCG Health
Mental Health America of California
National Health Law Program
National Union of Healthcare Workers
The California Association of Local Behavioral Health Boards and Commissions

Opposition

Association of California Life & Health Insurance Companies
California Association of Health Plans

Analysis Prepared by: Riana King / HEALTH / (916) 319-2097