
SENATE COMMITTEE ON HEALTH

Senator Akilah Weber Pierson, Chair

BILL NO: AB 2011
AUTHOR: Hart
VERSION: February 17, 2026
HEARING DATE: June 10, 2026
CONSULTANT: Teri Boughton

SUBJECT: Nonquantitative treatment limitations

SUMMARY: Codifies federal mental health and substance use disorder parity requirements regarding nonquantitative treatment limitations (NQTL) on mental health and substance use disorder benefits in comparison to medical and surgical benefits, including requirements to perform and document analyses comparing the design and application of each NQTL to assess impact on access and outcomes. Requires the comparative analyses to be provided to state regulators annually, and others upon request.

Existing federal law:

- 1) Establishes the Mental Health Parity and Addiction Equity Act (MHPAEA), which requires commercial health plans and issuers that offer mental health and substance use disorder benefits to do so in a manner comparable to medical and surgical benefits. Prohibits commercial health plans and issuers that provide mental health or substance use disorder benefits from placing limits on those benefits that are less favorable than the limits placed on medical and surgical benefits. Requires health plans and issuers to ensure that financial requirements, such as copayments, coinsurance, and deductibles, and treatment limitations, such as the number and frequency of visits that are applied to mental health and substance use disorder benefits are not more restrictive than the predominant requirements applied to most of the medical and surgical benefits. Prohibits health plans and insurers from imposing NQTLs such as medical necessity and utilization management on mental health and substance use disorder benefits that apply more restrictively than are applied to medical and surgical benefits. [42 U.S.C. Sect 300gg-26]
- 2) Establishes the Consolidated Appropriations Act of 2021 (CAA), which among other provisions, amends MHPAEA to require group health plans and issuers that provide both medical and surgical benefits, and mental health or substance use disorder benefits, to perform and document comparative analyses of the design and application of NQTLs that apply to mental health or substance use disorder benefits. Requires plans and issuers to make their analyses available to the Department of Treasury, Department of Labor, and the Department of Health and Human Services (HHS) [Departments] or applicable State authorities, upon request, effective February 10, 2021. Sets forth a process by which the Departments must evaluate the requested NQTL comparative analyses and enforce the comparative analyses requirements and requires the Departments to submit annually to Congress and make publicly available a report summarizing the comparative analyses requested for review by the Departments. [42 U.S.C. Sect 300gg-26 (a)(8)(A)-(C)]

Existing state law:

- 1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) and the California Department of Insurance (CDI) to regulate health insurers under the Insurance Code. [HSC

§1340, et seq. and INS §106, et seq.]

- 2) Requires a health plan contract to provide all covered mental health and substance use disorder benefits in compliance with MHPAEA and all rules, regulations and guidance issued pursuant to MHPAEA. [HSC §1374.76 and INS §10144.4]
- 3) Includes, in California’s essential health benefits (EHB) benchmark established pursuant to the federal Affordable Care Act, that MHPAEA applies to mental health and substance use disorder services under EHB, and any scope and duration limits imposed on benefits to be in compliance with MHPAEA, and all rules, regulations, and guidance issued pursuant to MHPAEA. [HSC §1367.005 and INS §10112.27]
- 4) Requires every health plan contract and insurance policy 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. This is California’s mental health and substance use disorder parity requirement. [HSC §1374.72 and INS §10144.5]
- 5) Requires health plans and insurers, if services are not available in network within geographic and timely access standards, to arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary follow-up services that, to the maximum extent possible, meet those geographically and timely access standards. Defines “arrange coverage to ensure the delivery of medically necessary out-of-network services” to include, but not be limited to, providing services to secure medically necessary out-of-network options that are available to the enrollee/insured within geographic and timely access standards. Requires the enrollee/insured to pay no more than the same cost-sharing that the enrollee would pay for the same covered services received from an in-network provider. [HSC §1374.72(d) and INS §10144.5(d)]
- 6) Requires health plans and insurers that offer contracts and policies described above to base any medical necessity determination or utilization review criteria used to determine medical necessity on current generally accepted standards of mental health and substance use disorder care. [HSC §1374.721 and INS §10144.52]

This bill:

2013 Final Rules provisions codification

- 1) Establishes definitions for “medical and surgical benefits,” “mental health benefits,” “substance use disorder benefits,” and “NQTL” consistent with a 2013 Final Rules related to MHPAEA. An NQTL includes prior authorization, formulary design, preferred providers, network tiers, and network participation standards.

2024 Final Rules provisions codification

- 2) Adds to the definition of an NQTL: reimbursement credentialing, step therapy, and other exclusions and restrictions.
- 3) Authorizes a health plan contract or health insurance policy to define the condition in accordance with applicable federal and state law, to the extent that generally recognized independent standards of current medical practice do not address whether a condition is a mental health condition.

- 4) Prohibits a health plan or health insurer from relying upon discriminatory factors or evidentiary standards to design an NQTL to be imposed on mental health and substance use disorder benefits. Specifies that a factor or evidentiary standard is discriminatory if the information, evidence, sources, or standards for the factor or evidentiary standards are biased or not objective in a manner that discriminates against mental health or substance use disorder benefits as compared to medical and surgical benefits.
- 5) Specifies that information, evidence, sources, or standards are considered to be biased or not objective in a manner that discriminates against mental health or substance use disorder benefits as compared to medical and surgical benefits if, based on all of the relevant facts and circumstances, the information, evidence, sources, or standards systemically disfavor access or are specifically designed to disfavor access to mental health or substance use disorder benefits as compared to medical and surgical benefits. States that “relevant facts and circumstances” include, but are not limited to:
 - a) Reliability of information, evidence, sources, standards and data;
 - b) Independence of the information, evidence, sources, and standards relied upon;
 - c) Analyses and methodologies employed to select the information and the consistency of application; and,
 - d) Any known safeguards deployed to prevent reliance on skewed data or metrics.
- 6) Specifies that evidence, sources, or standards are not considered biased or not objective if a plan or insurer has taken steps necessary to correct, cure, or supplement information. Includes requirements about considering historical plan data or other historical information.
- 7) Requires health plans and insurers to collect and evaluate relevant data to ensure benefits in a classification, in operation, are no more restrictive than the predominate NQTL applied to substantially all medical and surgical benefits to assess the impact of the NQTL on relevant outcomes related to access to mental health and substance use disorder benefits and medical and surgical benefits and carefully consider the impact as part of the plan’s or insurer’s evaluation. Prohibits the plan or insurer from disregarding relevant outcomes data associated with material differences in access to these benefits. Permits DMHC and CDI to specify in guidance the type, form, and manner of collection and evaluation for the data required in this bill.
- 8) Requires each comparative analysis to include the NQTL, including the specific terms of the plan contract or other relevant terms, the policies or guidelines, and the applicable sections of any other relevant documents, including provider contracts, that describe the NQTL.
- 9) Requires, for all benefits to which the NQTL applies, a description of which benefits are included in each classification, every factor considered or relied upon, as well as the evidentiary standards considered or relied upon to design or apply each factor, the sources from which each evidentiary standard was defined, and a description of any steps the plan or insurer has taken to correct, cure, or supplement anything considered biased or not objective.
- 10) Requires each comparative analysis to include a description of how each factor is used, and explanation of the evidentiary standards or other information sources, what the application of the factor depends upon, and specified explanations if more than one factor is identified. Requires each comparative analysis to evaluate the terms of the contract or policy as written, as specified, and to evaluate in operation, the processes, strategies, evidentiary standards and other factors, as specified. Requires the comparative analysis to address the findings and

conclusions and any actions taken or intended to address any potential areas of concern or noncompliance.

- 11) Requires a health plan or insurer to notify all enrollees or insureds within seven business days of final notice of determination if DMHC or CDI makes a final determination of noncompliance. Requires a copy of the notice to be provided to DMHC and CDI, any service provider involved in the claims process, and any fiduciary responsible for deciding benefit claims within the same time frame. Specifies information to be contained in the notice.
- 12) Authorizes DMHC and CDI, when there is a final determination on noncompliance with the comparative analysis, or MHPAEA, with respect to the NQTL, in addition to existing penalties, to direct the plan or insurer not to impose the NQTL with respect to mental health and substance use disorder benefits in the relevant classification, unless and until the plan or insurer demonstrates compliance with the requirements of this bill or with federal law or takes appropriate action to remedy the violation.

CAA

- 13) Requires a health plan or insurer to perform and document comparative analyses of the design and application of each NQTL and requires each comparative analysis to comply with this bill. Requires plans and insurers to also prepare and make available to DMHC or CDI, upon request, a written list of all NQTLs imposed under the plan contract or insurance policy.
- 14) Requires a copy of the comparative analysis to be made available to any applicable state authority, or an enrollee, insured, or authorized representative no later than 30 days after receiving a request.

New State Requirement

- 15) Requires the comparative analysis to be made available to DMHC and CDI on an annual basis beginning January 1, 2027.

FISCAL EFFECT: According to the Assembly Appropriations Committee, CDI anticipates no costs. Costs of an unknown, but likely minor and absorbable, amount to DMHC.

PRIOR VOTES:

Assembly Floor:	54 - 10
Assembly Appropriations Committee:	10 - 4
Assembly Health Committee:	13 - 2

COMMENTS:

- 1) *Author's statement.* According to the author, this bill addresses a serious risk patients face when seeking mental health or substance use disorder care. 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 mental health care as they do with traditional medical treatment. 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. 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) *CAA Final Rules.* The 2024 Final Rules amended the 2013 Final Rules, and added additional NQTL comparative analyses requirements and emphasize that plans must not design or apply financial requirements and treatment limitations that impose greater burden on access that are more restrictive to mental health and substance use disorder benefits than are imposed on access to medical and surgical benefits in the same classification of benefits. The 2024 Final Rules add new definitions for evidentiary standards, factors, processes and strategies. The 2024 Final Rules require coverage to provide meaningful benefits for the condition or disorder in every classification in which meaningful medical and surgical benefits are provided. The 2024 Final Rules require six content elements for comparative analysis.
- 3) *2024 Final Rules Process.* Under the 2024 Final Rules, the process for reviews, requires after an initial request for comparative analysis, the plan or issuer must submit it to the relevant Secretary within 10 business days, if it is determined insufficient additional information will be requested which must be provided within 10 business days. If there is an initial determination of noncompliance, the plan or issuer has 45 calendar days to specify if it will take action to comply and provide additional comparative analysis. If the Secretary makes a final determination of noncompliance, the plan or issuer must notify all participants, and enrollees not later than seven business days after the determination. Plans and insurers must make a copy of the comparative analysis available when requested by any applicable state authority, a participant, beneficiary, or enrollee who has received an adverse benefit determination related to mental health and substance use disorder benefits, and participants and beneficiaries in ERISA plans at any time.
- 4) *2024 Final Rules challenged.* On January 17, 2025, an association of employers (ERISA Industry Committee [ERIC]) filed suit in the U.S. District Court for the District of Columbia challenging provisions of the 2024 Final Rules on multiple issues including vague and undefined terms, onerous and unclear requirements and that the rule is contrary to law. On May 15, 2025, the Departments issued a statement that the ERIC litigation be held in abeyance while the Departments reconsider the 2024 Final Rules, including whether to rescind or modify the regulation. The Departments will not enforce the 2024 Final Rules or pursue enforcement actions, based on failure to comply prior to a final decision in the litigation and 18 months after the litigation is resolved. This enforcement relief applies only with respect to those portions of the 2024 Final Rules that are new in relation to the 2013 Final Rules. The Departments indicate that MHPAEA's statutory obligations, as amended by the CAA, continue to be in effect. HHS encourages states that are the primary enforcers of MHPAEA with respect to issuers to adopt a similar approach to enforcement. HHS will not consider a state to be failing to substantially enforce MHPAEA, as amended, because the state adopts such an approach.
- 5) *DMHC oversight.* Following the release of the MHPAEA 2013 Final Rules, DMHC required commercial health plans they regulate to conform to the new requirements and conducted initial compliance reviews, which included a desk review and a focused survey to ensure the plans put MHPAEA compliant benefit designs into practice. The desk review included a review of the classification of benefits and compliance with both Quantitative Treatment Limits (QTLs) and NQTLs. As a result of the focused compliance review, many health plans were required to update their policies and procedures and/or revise cost-sharing for services and treatment. Enrollees were reimbursed a total of \$517,375. Enforcement actions were also taken against plans found to be out of compliance. DMHC is also conducting focused

behavioral health investigations of all full-service commercial health plans regulated by DMHC. Under the CAA, health plans that impose NQTLs on mental health and substance use disorder benefits, are required to perform and document comparative analyses of the design and application of the NQTLs, providing specified, detailed information to demonstrate compliance. The CAA requires that a health plan's processes, strategies, evidentiary standards, or other factors used to apply the NQTLs to mental health and substance use disorder benefits in the classification, as written and in operation, are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used to apply the NQTLs to medical and surgical benefits in the classification. DMHC is conducting a compliance project to assess health plan compliance with the CAA.

- 6) *CDI oversight.* CDI announced regulations approved on June 26, 2025, described as enforcing California's Mental Health Parity Act following the passage of SB 855 (Wiener, Chapter 151, Statutes of 2020) and AB 988 (Bauer-Kahan, Chapter 747, Statutes of 2022). In November of 2025, the Association of California Life and Health Insurance Companies (ACLHIC) filed a complaint in Superior Court against CDI and the Insurance Commissioner challenging portions of the regulations specific to the 2024 Final Rules, indicating that the 2024 Final Rules are unconstitutionally vague and impose new requirements beyond MHPAEA relating to meaningful benefits, access and comparative analyses (similar to the ERIC litigation), and are not being enforced federally. The ACLHIC complaint also challenges a requirement by CDI for prior review of QTLs and NQTLs related home health services, and requirements on how clinicians must apply statutory nonprofit criteria in a case of inadequate or conflicting information or difficulty in making a judgement.
- 7) *Related legislation.* SB 1280 (Valladares) would have set an amount to be paid by health plans and insurers for out-of-network mental health and substance use disorder services at the greater of the average contracted rate or 125% of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered. SB 1280 would have prohibited a noncontracting individual health professional from billing or collecting an amount from the enrollee or insured for services that are more than the in-network cost-sharing amount as determined by the plan or insurer. *SB 1280 was not heard in the Senate Health Committee.*

AB 2551 (Elhawary) requires health plans and health insurers to collect data and report on the number of enrollees and insureds seeking out-of-network behavioral health care. Expands existing licensing board reporting requirements to include whether a license and registrant contracts with a health plan or health insurer to provide services. *AB 2551 is pending in the Senate Rules Committee.*

AB 2511 (Ahrens) requires the Department of Industrial Relations, in consultation with DMHC, CDI, the Department of Health Care Access and Information, and the Office of Health Care Affordability, to conduct a comparable worth study to examine and compare compensation and reimbursement for behavioral health providers for similarly situated medical-surgical providers and submit it to the Legislature by January 1, 2028. *AB 2511 was held in the Assembly Appropriations Committee.*

- 8) *Prior legislation.* SB 221 (Wiener, Chapter 724, Statutes of 2021) codifies existing timely access to care standards for health plans and health insurers, applies these requirements to Medi-Cal managed care plans, 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, and, prohibits contracting providers and employees from being disciplined for informing patients about timely access standards.

SB 855 (Weiner, Chapter 151, Statutes of 2020) expands California's mental health parity law with broader requirements on health plans and disability insurers to cover medically necessary treatment of mental health and substance use disorders under the same terms and conditions applied to other medical conditions; establishes new requirements for medically necessary care determinations and utilization review; and bans discretionary clauses in health plan contracts.

SB 857 (Committee on Budget and Fiscal Review, Chapter 31, Statutes of 2014) requires health plans and insurers to provide all covered mental health and substance use disorder benefits in compliance with federal MHPAEA and all rules, regulations, and guidance issued under MHPAEA. SB 857 permits DMHC to issue guidance until the director adopts regulations and requires DMHC to consult with CDI.

AB 88 (Thomson, Chapter 534, Statutes of 1999) requires health plans and insurers to cover the diagnosis and medically necessary treatment of "severe mental illness" of a person of any age, and of "serious emotional disturbances" of a child; requires parity under the same terms and conditions applied to other medical conditions; and requires parity with respect to enrollee cost-sharing for covered benefits.

16) *Support.* Insurance Commissioner (IC) Ricardo Lara, a co-sponsor of this bill, writes that the 2024 Final Rules clarify how existing statutory parity obligations must be evaluated and enforced, including standards for demonstrating compliance both as written and in operation, and that these regulations did not create new parity requirements; rather, they provided needed clarity to support consistent enforcement of existing law. The IC indicates this bill codifies federal standards into California statute to ensure continuity and enforceability, regardless of future federal administrative or judicial actions. The California Academy of Child and Adolescent Psychology, California State Association of Psychiatrists, the Steinberg Institute, and the Kennedy Forum are also co-sponsors, and they write that this bill does not create new benefit mandates, expand coverage, or impose new obligations on state regulators, and that regulators are already enforcing parity consistent with these standards under existing authority. The cosponsors say this bill simply affirms and preserves those practices in state law. The California Academy of Family Physicians writes this bill helps remove barriers to treatment, allowing family physicians to deliver the care their patients need without unnecessary restrictions or delays. The California Alliance of Child and Family Services indicate many organizations struggle with mental health parity issues, including network adequacy and reimbursement practices, and they support legislation that ensures stability for mental health providers and continued access to mental health and substance use care. Sponsors and supporters indicate that California has long been a national leader in advancing mental health parity, calling SB 855 the most comprehensive and expansive parity law in the country, which has set the standard for ensuring mental health and substance use disorder care are treated on par with physician health care, and this bill continues that leadership.

9) *Opposition.* The Association for Behavioral Health and Wellness (ABHW) is concerned that this bill will create confusion and further complicate the legal patchwork of laws attempting to enforce parity by codifying requirements that are unsettled at the federal level and could

be invalidated or modified. ABHW requests that this bill not advance until the federal parity landscape is settled and a clear, stable compliance framework is established. ABHW raises concerns that provisions in the 2024 Final Rules may not sufficiently account for clinically appropriate variation. ABHW also believes this bill would increase compliance obligations and expand reporting and enforcement exposure for regulated entities. The California Association of Health Plans (CAHP) and ACLHIC have significant concerns about moving forward with legislation while there is unresolved federal litigation, non-enforcement, and statutory interpretation disputes, indicating these concerns warrant extreme caution rather than codification. CAHP/ACLHIC argue that the 2024 Final Rules exceed statutory authority and introduce an outcomes-based compliance standard that does not meaningfully improve parity enforcement or patient access. CAHP/ACLHIC indicate updating comparative analyses to meet new standards that are highly resource-intensive and may not result in substantive changes but will significantly increase compliance burdens and legal risk.

10) *Policy comments.*

- a) Existing law already requires health plans and insurers to comply with all MHPAEA rules, regulations and guidance.
- b) With the challenge to, and reconsideration of, the 2024 Final Rules it is likely that it will be rescinded or modified in which case the 2024 Final Rules may no longer be required as currently published. If the ERIC challenge and ACLHIC challenge are found to have merit, in that there are vague, unclear and unspecified terms and requirements, enactment of this bill may also be difficult for plans and insurers to implement without additional state guidance or regulations. At a minimum state regulations or guidance may be necessary.
- c) The requirement for annual reporting to state regulators contained in this bill is not in MHPAEA or its rules or regulations. The existing federal requirement is for plans to provide the comparative analysis upon request. Federal enforcement agencies have indicated in their annual reports to Congress that their review and enforcement is labor intensive.

11) *Amendments.* The Committee may wish to amend this bill to address any potential conflicts.

SUPPORT AND OPPOSITION:

Support: California Academy of Child and Adolescent Psychiatry (co-sponsor)
 California State Association of Psychiatrists (co-sponsor)
 Insurance Commissioner Ricardo Lara / California Department of Insurance (co-sponsor)
 Steinberg Institute (co-sponsor)
 The Kennedy Forum (co-sponsor)
 Board of Behavioral Sciences
 California Academy of Family Physicians
 California Alliance of Child and Family Services
 California Association of Alcohol and Drug Program Executives, INC.
 California Behavioral Health Association
 California Chapter of the American College of Emergency Physicians
 California Children's Hospital Association
 California Chronic Care Coalition
 California Coalition for Behavioral Health
 California Consortium of Addiction Programs and Professionals

California Medical Association
California Psychological Association
Coalition for Developmental Approaches
County Behavioral Health Directors Association
Greenhouse Therapy Center
Health Access California
Inseparable
MCG Health
Mental Health America of California
National Alliance on Mental Illness
National Health Law Program
National Union of Healthcare Workers
Rural County Representatives of California
The California Association of Local Behavioral Health Boards and Commissions
Urban Counties of California

Oppose: America's Health Insurance Plans
Association for Behavioral Health and Wellness
Association of California Life & Health Insurance Companies
California Association of Health Plans

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