SENATE COMMITTEE ON APPROPRIATIONS
Senator Sabrina Cervantes, Chair
2025 - 2026 Regular Session

AB 2011 (Hart) - Nonquantitative treatment limitations

Version: June 15, 2026
Urgency: No
Hearing Date: June 22, 2026

Policy Vote: HEALTH 8 - 2
Mandate: Yes
Consultant: Agnes Lee

Bill Summary: AB 2011 would impose requirements on health plans and insurers regarding nonquantitative treatment limitations (NQTLs) on mental health or substance use disorder benefits.

Fiscal Impact:

- The Department of Managed Health Care (DMHC) estimates costs of approximately $18,454,000 in 2026-27, $46,668,000 in 2027-28, $67,835,000 in 2028-29, $70,952,000 in 2029-30, $72,166,000 in 2030-31, and $72,386,000 in 2031-32 and annually thereafter for state administration (Managed Care Fund).

- The California Department of Insurance (CDI) anticipates no fiscal impact.

Background: The Federal Mental Health Parity and Addiction Equity Act (MHPAEA) 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. The MHPAEA prohibits health plans and issuers 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. In order to assess compliance, the MHPAEA requires 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 as compared to medical and surgical benefits. In 2024, the federal government issued "Final Rules" which included additional NQTL comparative analyses requirements related to implementation of the MHPAEA. In 2025, the ERISA Industry Committee (ERIC) filed a suit against the federal government challenging the 2024 Final Rules.

California law requires health plans and insurers to provide all covered mental health and substance use disorder benefits in compliance with MHPAEA and all rules, regulations and guidance issued. State law also requires every health plan and insurer 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.

Proposed Law: Specific provisions of the bill would:

- Provide that NQTL includes, but is not limited to, all of the following:

- 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.

- Formulary design for prescription drugs.

- For health plans/insurers with multiple network tiers, including, for example, preferred providers and participating providers, network tier design.

- 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 contract/policy.

- Health plan/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.

- 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.

- Exclusions based on failure to complete a course of treatment.

- 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 contract/policy.

- Prohibit health plans and insurers from relying upon discriminatory factors or evidentiary standards to design an NQTL to be imposed on mental health or substance use disorder benefits, as specified.

- Require health plans and insurers to collect and evaluate relevant data to assess the impact of the NQTL on relevant outcomes related to access to mental health and substance use disorder benefits and medical/surgical benefits and carefully consider the impact as part of the plan's/insurer's evaluation, as specified.

- Require health plans and insurers that provide both medical/surgical benefits and mental health or substance use disorder benefits and that impose any NQTLs on mental health or substance use disorder benefits to perform and document comparative analyses of the design and application of each NQTL applicable to mental health or substance use disorder benefits, as specified.

- Require health plans and insurers to make the comparative analyses available, as specified.

- Provide that to the extent that a provision is determined to impose requirements that conflict with or materially differ from federal regulations, that provision must be

reviewed by DMHC/CDI; and require DMHC/CDI to issue guidance to plans/insurers on compliance based on the conflict or material difference.

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