

Date of Hearing: March 24, 2026

ASSEMBLY COMMITTEE ON HEALTH  
Mia Bonta, Chair  
AB 2233 (Ta) – As Introduced February 19, 2026

**SUBJECT:** Behavioral health treatment plans.

**SUMMARY:** Prohibits a health plan or health insurer from imposing restrictions on the utilization of authorized treatment hours for pervasive developmental disorder (PDD) or autism within a behavioral health treatment (BHT) plan's 6-month authorization period. Requires authorized hours to remain available for use throughout the authorization period.

**EXISTING LAW:**

- 1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans and the California Department of Insurance (CDI) to regulate health insurance. [Health and Safety Code (HSC) § 1340, *et seq.*; Insurance Code (INS) § 106, *et seq.*]
- 2) Requires every health plan contract and health insurance policy that provides hospital, medical, or surgical coverage to cover BHT for PDD or autism. Requires the coverage to be provided in the same manner and to be subject to the same requirements as provided in California's mental health parity law. [HSC § 1374.73 and INS § 10144.51]
- 3) Prohibits a health plan contract or health insurance policy from requiring an enrollee previously diagnosed with PDD or autism to receive a rediagnosis to maintain coverage for BHT. Prohibits a plan or insurer from discontinuing or delaying existing treatment while waiting for a rediagnosis to be completed. [HSC § 1374.73 and INS § 10144.51]
- 4) Defines BHT for purposes of 2) above as professional services and treatment programs, including applied behavior analysis and evidence-based intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with PDD or autism and that meet specified criteria regarding the treatment plan. Specifies that licensed physicians and psychologists must prescribe, develop and supervise treatment, and administer a treatment plan. [HSC § 1374.73 and INS § 10144.51]
- 5) Specifies that BHT services can be provided by, among others, the following: a qualified autism service professional or qualified autism service paraprofessional supervised and employed by a qualified autism services provider. [HSC § 1374.73 and INS § 10144.51]
- 6) Requires a BHT plan to have measurable goals over a specific timeline that is developed and approved by the qualified autism services provider for the specific patient being treated. Requires the treatment plan to be reviewed no less than once every six months by the qualified autism services provider and modified whenever appropriate, and requires the qualified autism services provider to do all of the following:
  - a) Describe the patient's behavioral health impairments or developmental challenges that are to be treated;

- b) Design an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan or insurer's goal and objectives, and the frequency at which the patient's progress is evaluated and reported;
- c) Provide intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating PDD or autism; and,
- d) Discontinue intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate. [HSC § 1374.73 and INS § 10144.51]

**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 will protect people with disabilities from losing coverage of essential treatment that has already been prescribed to them from a doctor and approved by a healthcare plan if they are unable to make it to an appointment. The author states that this bill will not infringe on a healthcare plan's discretion to conduct utilization reviews of the services and treatment being provided whenever appropriate. The author continues that this bill simply ensures that once care is prescribed by a doctor and approved, patients are able to use it. The author states that utilization reviews are intended to ensure appropriate care, not to undermine approved treatment through administrative design. The author argues that when patients lose authorized hours due to inflexible utilization rules, care is disrupted, progress may be delayed or reversed, and families face unnecessary stress navigating coverage limitations unrelated to medical need. The author concludes that California has long led the nation in health care consumer protections, and this bill addresses a narrow but significant gap in existing law to ensure that approved care is truly available to those who need it.
- 2) **BACKGROUND.** PDDs – now known as autism spectrum disorder (ASD) – are a group of developmental delays that affect social and communication skills. According to the California Health Benefits Review Program, ASD is characterized by deficits in social interactions and communication, sensory processing, stereotypic (repetitive) behaviors or interests, and sometimes cognitive function. The symptoms of ASD fall along a continuum, ranging from mild impairment to profound disability. ASD diagnoses are often made early in life, as individuals often demonstrate symptoms in early childhood. The cause (or causes) of ASD remain unknown, and research into genetic etiology, as well as environmental factors, continues to be explored. There is no cure for ASD; however, there is evidence that treatment, including BHT, may improve some symptoms.

California law requires BHT coverage and requires a qualified autism service provider to review a treatment plan no less than once every six months and modify whenever appropriate. This bill would prohibit health plans from restricting hours authorized under a BHT plan for the six month period between reviews.

- 3) **SUPPORT.** The Autism Business Association (ABA) supports this bill, stating that their members (autism providers) have observed that health plans have initiated a practice of imposing weekly caps on behavioral services. ABA argues that despite patients receiving authorizations for six-month periods, these arbitrary weekly limits restrict the delivery of necessary care. ABA continues that under this current practice, if a patient misses a session

for any reason—whether due to illness, family emergency, or provider availability—they are strictly prohibited from making up those hours later in the authorization period. ABA argues that this rigidity disrupts the continuity of care, prevents individuals from receiving the full dosage of treatment deemed medically necessary, and ultimately hinders therapeutic progress. ABA concludes that by ensuring that authorized service hours can be utilized flexibly within the authorization period, this bill protects patients from losing essential care and allows providers to deliver treatment that is both consistent and effective.

#### 4) PREVIOUS LEGISLATION.

- a) AB 951 (Ta), Chapter 84, Statutes of 2025, prohibits a health care service plan contract or health insurance policy from requiring an enrollee or insured previously diagnosed with PDD or autism to receive a rediagnosis to maintain coverage for BHT for their condition.
- b) SB 402 (Valladares), Chapter 413, Statutes of 2025, repeals the definition of qualified autism service provider, qualified autism service professional, and qualified autism service paraprofessional in the Health and Safety Code and Insurance Code and recasts them in the Business and Professions Code.
- c) AB 1977 (Ta) of 2024 would have prohibited a health plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025 from requiring an enrollee or insured previously diagnosed with PDD or autism to be reevaluated or review a new behavioral diagnosis to maintain coverage for BHT for PDD or autism. AB 1977 was vetoed by Governor Newsom, who stated:

“This bill would prohibit a health plan from requiring an enrollee who was previously diagnosed with PDD or autism to be reevaluated or receive a new behavioral diagnosis to maintain coverage.

Under existing law, health plans may require utilization review (UR) to ensure enrollees receive the right care at the right time and to control costs for unnecessary services. Plans are prohibited from conducting UR more frequently than prescribed or recommended by the nonprofit professional association for the relevant clinical specialty, such as the CASP. While plans should make every effort to streamline UR processes and reduce unnecessary burdens for families, prohibiting reasonable UR entirely does not strike an appropriate balance.”

- d) AB 2449 (Ta) of 2024 would have required that the Qualified Applied Behavior Analysis Credentialing Board be recognized as a national entity that may certify a qualified autism services provider, and would have authorized the certification to be accredited by the American National Standards Institute. AB 2499 was held on the Senate Appropriations Committee suspense file.
- e) SB 805 (Portantino), Chapter 635, Statutes of 2023, expands the criteria for a qualified autism service professional to include a psychological associate, an associate marriage and family therapist, an associate clinical social worker, or an associate professional clinical counselor, as specified. Requires those positions to meet the criteria for a Behavioral Health Professional, as provided. Requires the Department of Developmental Services (DDS) to adopt regulations, on or before July 1, 2026, to address the use of Behavioral Health Professionals and Behavioral Health Paraprofessionals in BHT group

practice. Requires DDS to establish rates and the educational or experiential qualifications and professional supervision requirements necessary for these positions to provide behavioral intervention services, as specified.

- f) SB 562 (Portantino) of 2021 would have revised the definition of BHT to require the services and treatment programs provided to be based on behavioral, developmental, relationship-based, or other evidence-based models. The bill would have revised the definition of a qualified autism service professional to include a registered, certified, or licensed associate or assistant regulated by one of a list of specified professional boards, and supervised by a qualified autism services provider practicing in the associate's or assistant's field of medicine. SB 562 would have revised the training requirements for a qualified autism service paraprofessional by authorizing training to be provided by a qualified autism services provider practicing the evidence-based treatment modality that the qualified autism service paraprofessional will administer. The bill would have required the qualified autism services provider to design an intervention plan that includes parent or caregiver participation, when clinically appropriate, that is individualized to the patient, or to develop an alternative plan if a parent or caregiver cannot participate, as specified. The bill would have prohibited using the lack of parent or caregiver participation, implementation of an alternative plan, or the setting, location, or time of treatment as a reason to deny or reduce coverage for medically necessary services. SB 562 was vetoed by Governor Newsom, who stated in part:

“Early diagnosis of ASD and subsequent participation in evidence-based intervention and therapies, provided by licensed and certified individuals, make all the difference in an individual's long-term health outcomes. Research finds that Black and Latino children are often misdiagnosed and diagnosed later with ASD than their white peers. It is incumbent upon us to ensure that any intervention is medically-necessary, evidence-based and grounded in research that is conducted to reduce disparities.”

- g) SB 855 (Wiener), Chapter 151, Statutes of 2020, requires commercial health plans and insurers to provide full coverage for the treatment of all mental 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. California law requires health care coverage of behavioral health and wellness screenings.
- h) AB 796 (Nazarian), Chapter 493, Statutes of 2016, eliminates the sunset date on the health insurance mandate to cover BHT for pervasive developmental disorder or autism.
- i) SB 126 (Steinberg) Chapter 680, Statutes of 2013, extends, until January 1, 2017, the sunset date of an existing state health benefit mandate that requires health plans and health insurance policies to cover BHT for pervasive developmental disorder or autism and requires plans and insurers to maintain adequate networks of these service providers.
- j) SB 946 (Steinberg and Evans), Chapter 650, Statutes of 2011, imposed a set of rules regarding BHT that health plans and health insurers in California must cover for individuals with autism and PDD. SB 946 also identifies the required qualifications of

individuals who provide BHT, and permits individuals who are not licensed by the state to provide BHT, as long as the detailed criteria set forth in SB 946 are met. Additionally, SB 946 specifies requirements of treatment plans, including measurable goals for a specific patient and review no less than once every six months and modified whenever appropriate.

**REGISTERED SUPPORT / OPPOSITION:**

**Support**

Abedi INC.  
Aces 2020, LLC  
Applied Behavior Consultants, INC.  
Autism Behavior Services, INC.  
Autism Business Association  
Autism Learning Partners  
Behavior Frontiers, LLC  
Bloom Behavioral Health INC  
Center for Autism and Related Disorders (CARD)  
Coalition for Developmental Approaches  
Hearts of ABA  
National Coalition for Access to Autism Services  
One individual

**Opposition**

None on file

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