SENATE COMMITTEE ON HEALTH
Senator Akilah Weber Pierson, Chair

BILL NO: AB 2233
AUTHOR: Ta
VERSION: February 19, 2026
HEARING DATE: June 3, 2026
CONSULTANT: Teri Boughton

SUBJECT: Behavioral health treatment plans

SUMMARY: Prohibits health plans and insurers from imposing restrictions on the utilization of authorized treatment hours within a six-month authorization period, including weekly caps or limitations that result in the forfeiture of unused hours. Requires authorized hours to remain available for use throughout the authorization period to ensure the enrollee or insured may fully access approved treatment.

Existing federal law: Requires, under the federal Mental Health Parity and Addiction Equity Act (MHPAEA), commercial health plans 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 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/surgical benefits. Requires health plans 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 or substance use disorder benefits, are not more restrictive than the predominant requirements applied to most of the medical and surgical benefits. Prohibits health plans from imposing non-quantitative treatment limits such as medical necessity and utilization management on mental health and substance use disorder benefits that apply more restrictively than are applied to medical/surgical benefits. [42 U.S.C. Sect 300gg-26]

Existing law:
1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Services Plan Act of 1975; the California Department of Insurance (CDI) to regulate health and other insurers; the Department of Health Care Services (DHCS) to administer the Medi-Cal program; and the Department of Developmental Disabilities to administer services to people with developmental disabilities. [HSC §1340, et seq., INS §106, et seq., WIC §14000, et seq., and WIC §4400, et seq.]

2) Requires, under California's mental health parity law, 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. [HSC §1374.72 and INS §10144.5]

3) Requires every health plan contract and health insurance policy that provides hospital, medical, or surgical coverage to cover behavioral health treatment for pervasive developmental disorder 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]

4) Prohibits health plans and insurers from requiring an enrollee or insured previously diagnosed with pervasive developmental disorder or autism to receive a rediagnosis to maintain coverage for behavior health treatment for pervasive developmental disorder or autism. Permits a plan or insurer to require utilization review, which is distinct from rediagnosis. [HSC §1374.73 and INS §10144.51]

5) Requires a behavioral health treatment plan to have measurable goals over a specific timeline that is developed and approved by a Qualified Autism Service (QAS) provider for the specific patient being treated, reviewed no less than once every six months by the QAS provider and modified whenever appropriate, and to be consistent with existing law that applies to applied behavioral analysis services or intensive behavioral intervention, or both, provided by regional center vendors, as specified, and does all of the following:
   a) Describes the patient's behavioral health impairments or developmental challenges that are to be treated;
   b) Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported;
   c) Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism; and,
   d) Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate. [HSC §1374.73 and INS §10144.51]

6) Exempts Medi-Cal managed care plans from the requirements above. [HSC §1374.73 and INS §10144.51]

This bill:
1) Prohibits health plans and insurers from imposing restrictions on the utilization of authorized treatment hours within a six-month authorization period, including weekly caps or limitations that result in the forfeiture of unused hours.

2) Requires authorized hours to remain available for use throughout the authorization period to ensure the enrollee or insured may fully access approved treatment.

FISCAL EFFECT: According to the Assembly Appropriations Committee, CDI estimates costs of $6,000 in fiscal year (FY) 2026-27 and $18,000 in FY 2027-28 to review policy forms and enforce the new requirements (Insurance Fund), and DMHC estimates minor and absorbable costs.

PRIOR VOTES:

Assembly Floor:	66 - 0
Assembly Appropriations Committee:	13 - 0
Assembly Health Committee:	16 - 0

COMMENTS:
1) *Author's statement.* According to the author, this bill will protect people with disabilities from losing coverage of essential treatment that has already been prescribed to them by a healthcare provider and approved by a healthcare plan if they are unable to make it to an appointment. This bill will not infringe on a healthcare plan's discretion to conduct utilization reviews of the services and treatment being provided whenever appropriate. This

bill simply ensures that once care is prescribed and approved, patients are actually able to use it. Utilization reviews are intended to ensure appropriate care, not to undermine approved treatment through administrative design. 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. California has long led the nation in health care consumer protections. 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 on autism.* According to the California Health Benefits Review Program (CHBRP) analysis of SB 562 (Portantino of 2022), autism spectrum disorder is a developmental disability characterized by deficits in social interactions and communication, sensory processing, stereotypic (repetitive) behaviors or interests, and sometimes cognitive function. Symptoms fall along a continuum, ranging from mild impairment to profound disability. Reliable diagnoses can be made by age two, though the median age is 51 months, with black children being diagnosed later than white children. The causes remain unknown though research into genetic etiology and environmental factors continue to be explored.

3) *Behavioral health therapy.* According to CHBRP, behavioral health therapy aims to modify the behavior of individuals with autism spectrum disorder and improve their cognitive, language and social functioning by assessing environmental stimuli and reinforcing appropriate responses. Some treatment modalities are based primarily on behavioral theory (e.g. Applied Behavioral Analysis), while others are based primarily on developmental theory or on a hybrid of behavioral and developmental theory. CHBRP found evidence for the medical effectiveness of all of these modalities, though there were significant variations in how effective each modality was for particular outcomes.

4) *Medicaid.* This bill applies to state-regulated commercial health insurance, not individuals covered by Medi-Cal or Medi-Cal managed care plans. However, there have been federal reports on questionable billing patterns related to applied behavior analysis services, and the Trump administration has begun intensely focusing on fraud in the Medicaid program. In April of 2026, DHCS announced a change in utilization management practices related to applied behavior analysis and behavioral health treatment. DHCS indicates that utilization of these services has increased significantly, with some patterns of overuse and misuse, and, that DHCS' current policies are less stringent than peer states and/or clinical guidelines. DHCS is establishing utilization thresholds that would trigger authorization reviews for services exceeding those defined thresholds (e.g., more than 25 hours per week) along with a defined exception process on medical necessity. DHCS indicates that these thresholds are intended to align with clinical guidelines for appropriate levels of care, and that could include age-based thresholds when supported by evidence. DHCS is also requiring an autism spectrum disorder diagnosis for enrollees age five and older in order to receive applied behavioral analysis services, and additional supporting documentation such as treatment plans and progress notes to support medical necessity and authorizations.

5) *Related legislation.* SB 874 (Weber Pierson) requires the DHCS to ensure unlicensed providers of behavioral health treatment services are fingerprinted; convene a stakeholder workgroup to review the implementation of behavioral health treatment services in the Medi-Cal program in 2027 and 2028; release and maintain clinical guidance on the provision of the behavioral health treatment services; and, submit a report to the Legislature on the provision of behavioral health treatment services by January 1, 2029. *SB 874 is pending in the*

Assembly Health Committee.

AB 277 (Alanis) requires persons who provide behavioral health treatment services to undergo a background check if they do not hold a current and valid license issued by a California state licensing board that requires a fingerprint-based background check. *AB 277 is set for hearing on June 1, 2026, in the Senate Business, Professions, and Economic Development Committee.*

6) *Prior legislation.* SB 402 (Valladares, Chapter 413, Statutes of 2025) moves the existing statutory framework outlining the qualifications for qualified autism service providers, qualified autism service professionals, and qualified autism service paraprofessionals from the Health and Safety Code and Insurance Code to the Business & Professions Code.

   AB 951 (Ta, Chapter 84, Statutes of 2025) prohibits a health plan or insurer from requiring an enrollee or insured with a diagnosis of pervasive developmental disorder or autism, to receive a rediagnosis in order to maintain coverage for behavioral health treatment.

   AB 1977 (Ta of 2024) would have prohibited a health plan contract or health insurance policy from requiring an enrollee or insured previously diagnosed with pervasive developmental disorder or autism to be reevaluated or receive a new behavioral diagnosis to maintain coverage for behavioral health treatment for pervasive developmental disorder or autism. *AB 1977 was vetoed by Governor Newsom, who wrote:*

   > *This bill would prohibit a health plan from requiring an enrollee who was previously diagnosed with pervasive developmental disorder (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 Council of Autism Service Providers (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.*

7) *Support.* The Autism Business Association (ABA), the sponsor of this bill, writes that plans have initiated a practice of imposing weekly caps on behavioral services despite patients receiving authorizations for six-month periods, which restrict the delivery of necessary care. The Coalition for Developmental Approaches writes that weekly caps "disregard the full six-month authorization periods typically granted, can prevent individuals from accessing the care they need to achieve meaningful outcomes. If a session is missed due to illness or scheduling problems, individuals are prohibited from making up those approved hours later in the authorization period. Weekly caps without any options for makeup sessions are arbitrary and inappropriate to the nature of behavioral health treatment for autistic children." The National Coalition for Access to Autism Services writes that "a damaging loophole has allowed insurers to impose weekly or monthly caps on how authorized hours can be used with that [six-month authorization] period and has allowed [health plans] to extinguish unused hours at the end of a billing cycle without carrying them forward. The real-world consequences of this practice are serious. A child may miss sessions due to illness, a provider scheduling conflict, or any number of life events… This creates an artificial reduction in care that is not driven by clinical judgement, medical

necessity, or the child's treatment plan. It is driven solely by administrative convenience for the insurer."

8) *Opposition.* The California Association of Health Plans (CAHP) and the Association of California Life and Health Insurance Companies (ACLHIC) believe this bill removes their ability to conduct utilization management on applied behavioral analysis therapy. CAHP and ACLHIC raise concerns about bad actors exploiting the system and that this bill could incentivize fraudulent billing and undermine clinical safety. CAHP and ACLHIC refer to Office of Inspector General audits of state Medicaid programs and a Wall Street Journal article on growth in companies providing this treatment and increased Medicaid payments. An individual also writes in with concerns that "this bill risks perpetuating known fraud vulnerabilities in California's behavioral health treatment system by removing practical utilization constraints without sufficient safeguards."

9) *Policy comment.* This bill does not apply to Medi-Cal. However, it is reasonable to assume that commercial health plans are experiencing similar patterns of concerning billings as has been identified nationally in Medicaid programs. Commercial health insurers are expected to responsibly manage the expenditure of premium dollars and facilitate access to quality health care services and treatment. Utilization management practices must be consistent with clinical guidelines and be consistent with mental health parity requirements. This bill may need amendments to maintain appropriate utilization management by health plans.

10) *Suggested amendments agreed to by the author.*

A health care service plan shall not impose restrictions on the utilization of authorized treatment hours within the six-month authorization period, including weekly caps or limitations that result in the forfeiture of unused hours ***due to unavoidable circumstances, including patient illness, family travel, or provider unavailability when the use of the hours are reasonably consistent with the treatment plan and clinical guidelines, and are documented in the treatment plan or progress reports***. Authorized hours shall remain available for use throughout the authorization period to ensure the enrollee may fully access their approved treatment ***when the use of the hours are reasonably consistent with the treatment plan and clinical guidelines, and are documented in the treatment plan or progress reports.***

(h) Nothing in this section shall prohibit a health plan/insurer from applying evidence-based utilization management or a clinically appropriate schedule, provided an enrollee/insured is permitted to reasonably make up missed services within the authorization period.

SUPPORT AND OPPOSITION:

Support: Autism Business Association (sponsor)
ABEDI, Inc.
Accelerated Behavioral Change, Inc.
ACES 2020, LLC
American Academy of Pediatrics, California
Autism Behavior Services, Inc.
Autism Learning Partners
Autism Speaks

Autism Spectrum Therapies
Behavior Frontiers, LLC.
Bright Minds
California Association for Behavior Analysis
California Behavioral Health Association
California Health Coalition Advocacy
California Psychological Association
Center for Autism and Related Disorders
Coalition for Developmental Approaches
National Coalition for Access to Autism Services
Occupational Therapy Association of California
Rady Children's Hospital
Special Needs Network, INC.
Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board

Oppose: Association of California Life & Health Insurance Companies
California Association of Health Plans
One individual

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