

Date of Hearing: April 8, 2026

ASSEMBLY COMMITTEE ON LABOR AND EMPLOYMENT

Liz Ortega, Chair

AB 2511 (Ahrens) – As Introduced February 20, 2026

SUBJECT: Behavioral Health Provider Comparable Worth Study

SUMMARY: Requires the Department of Industrial Relations (DIR), in consultation with the Department of Managed Health Care (DMHC), the Department of Insurance (DOI), the Department of Health Care Access and Information (HCAI), and the Office of Health Care Affordability (OHCA), to conduct a comparable worth study (study) to examine and compare compensation and reimbursement for behavioral health providers with that for similarly situated medical-surgical providers. On or before January 1, 2028, the DIR shall submit a report to the Legislature containing the findings of the study. Specifically, **this bill:**

Definitions

- 1) Defines a “behavioral health provider” to mean a psychiatrist, psychologist, licensed clinical social worker, licensed marriage and family therapist, licensed professional clinical counselor, psychiatric mental health nurse practitioner, or other licensed or certified professional who provides mental health or substance use disorder treatment services.
- 2) Defines “compensation” to mean all forms of payment made to an employed provider for health care services, including wages, salaries, and benefits.
- 3) Defines a “health system” to mean a hospital, hospital system, integrated delivery system, or other organization that both receives payments from health care service plans or health insurers for health care services and employs or contracts with health care providers to deliver those services.
- 4) Defines “intermediary” to mean a platform, independent practice association, medical group, managed behavioral health care organization, or other entity that contracts with health care service plans or health insurers to arrange for or provide access to health care services and that, in turn, employs or contracts with health care providers to deliver those services.
- 5) Defines “medical-surgical provider” to mean a physician, physician assistant, nurse practitioner, registered nurse, or other licensed or certified health care professional who provides medical or surgical treatment services, excluding behavioral health services.
- 6) Defines “platform” to mean a digital health company or other technology-enabled entity that contracts with health care service plans, managed behavioral health care organizations, health insurers, or health systems to provide access to health care providers.

Requirements for the compensation study

- 1) Requires the DIR, in consultation with the DMHC, the DOI, the HCAI, and the OHCA, to conduct a study to examine and compare compensation and reimbursement for behavioral health providers with compensation and reimbursement for similarly situated medical-surgical providers.
- 2) Requires the study to analyze compensation and reimbursement across the following payment flows:
 - a) Payments made by health care service plans and health insurers directly to behavioral health providers and medical-surgical providers.
 - b) Payments made by health care service plans and health insurers to intermediaries and health systems for behavioral health services and medical-surgical services.
 - c) Payments made by intermediaries and health systems to behavioral health providers and medical-surgical providers, whether as employee compensation or as payments to independent contractors.
- 3) In conducting the study, the DIR shall, among other things, do the following:
 - a) Develop a methodology for determining which behavioral health provider roles are comparable to which medical-surgical provider roles, considering factors including, but not limited to, all of the following:
 - 1) Required skills and expertise.
 - 2) Education requirements.
 - 3) Specialized training.
 - 4) Licensure and certification requirements.
 - 5) Similarity of working conditions.
 - b) Collect and analyze compensation and reimbursement data for each provider role, as specified, across each of the payment flows.
 - c) Quantify any disparities in compensation and reimbursement between each set of comparable behavioral health and medical-surgical provider roles, for each payment flow.

Data to be reported to the DIR

- 1) Requires, with respect to payments made directly to providers, each health care service plan and health insurer to report all of the following:

- a) Reimbursement rates for specific procedure codes and service categories for both behavioral health services and medical-surgical services.
 - b) The distribution of reimbursement rates, as specified, by provider type.
 - c) Total aggregate payments to behavioral health providers and to medical-surgical providers.
- 2) Requires, with respect to payments made to intermediaries and health systems, each health care service plan and health insurer to report all of the following:
- a) The identity of each intermediary and health system with which the plan or insurer contracts for behavioral health services or medical-surgical services.
 - b) Total payments made to each intermediary and health system for behavioral health services and for medical-surgical services.
 - c) The contractual structure of each arrangement, including whether payments are made on a capitated, fee-for-service, or other basis, and any risk-sharing or performance-based payment terms.
- 3) Requires, with respect to payments received from health care service plans and health insurers, each intermediary and health system to report all of the following:
- a) The identity of each health care service plan and health insurer from which the intermediary or health system receives payment for behavioral health services or medical-surgical services.
 - b) Total payments received from each health care service plan and health insurer for behavioral health services and for medical-surgical services.
 - i) The contractual structure of each arrangement, including whether payments are received on a capitated, fee-for-service, or other basis, and any risk-sharing or performance-based payment terms.
- 4) Requires, with respect to payments made to providers, each intermediary and health system to report all of the following:
- a) For employed providers, compensation data including wages, salaries, and benefits, by provider type.
 - b) For contracted providers, payment rates or amounts, by provider type, including per-service, per-session, or other payment structures.
 - c) The distribution of payments to providers, as specified, by provider type.

- d) Total aggregate payments to behavioral health providers and to medical-surgical providers.
- 5) States that 3) and 4) above only apply to an intermediary that employs or contracts with 25 or more providers.

Data requirements to be developed by the DIR and others

- 1) Requires the DIR, in consultation with DMHC, the DOI, HCAI, and the OHCA, and taking into account data that can be aggregated from information already required to be reported to all of the entities enumerated above, to develop reporting requirements specifying the data elements to be reported pursuant to the section above, the format for reporting, and the deadlines for submission.
- 2) Requires DIR, the DMHC, the DOI, the HCAI, and the OHCA to protect the confidentiality of any proprietary or commercially sensitive information submitted pursuant to this bill and to publish only aggregated data that does not reveal information about individual entities or individual providers.

Penalties for noncompliance

- 1) Provides that an entity that fails to comply with the reporting requirements established pursuant to this bill shall be subject to a civil penalty of up to ten thousand dollars (\$10,000) per day for each day of noncompliance, to be assessed and collected by the DIR.

Submission of the report

- 1) Requires, on or before January 1, 2028, the DIR to submit a report to the Legislature containing the findings of the study, to include, among other things:
 - a) The methodology used to determine comparability between behavioral health provider roles and medical-surgical provider roles.
 - b) The medical-surgical provider roles identified for inclusion in the study.
 - c) For each payment flow, a quantification of any disparities in compensation and reimbursement between each set of comparable behavioral health and medical-surgical provider roles.
 - d) An analysis of how compensation and reimbursement levels change as payments pass through intermediaries and health systems, including any differential treatment of behavioral health services as compared to medical-surgical services.
 - e) Identification of any discrepancies between data reported by payers and data reported by recipients regarding the same payment flows.

Implementing Regulations

- 1) Authorizes the DIR to adopt regulations to implement the above. Any regulations adopted pursuant to this section shall be adopted as emergency regulations, as specified.

EXISTING LAW:

- 1) Establishes within the Labor and Workforce Development Agency the DIR that has among its duties the function of fostering, promoting, and developing the welfare of the wage earners of California, improving their working conditions, and advancing their opportunities for profitable employment. Labor Code §50 and §50.5.

FISCAL EFFECT: Unknown.

COMMENTS: This bill is double-referred to the Assembly Health Committee upon passage from this Committee.

As stated in the author's background materials to the committee, disparities in reimbursement rates and compensation for behavioral health providers versus medical-surgical providers has led to a full-blown behavioral health crisis. Such disparities have real consequences, impacting behavioral health professionals and the patients they serve in a number of ways, including:

- High turnover rates among behavioral health staff.
- Difficulty meeting the growing demand for mental health and substance use disorder treatment.
- Consumers experiencing long wait times to see behavioral health care providers.
- Too few behavioral health providers participating in insurance networks.
- Consumers being forced to pay out of pocket to receive timely behavioral health care.

Out-of-network usage by patients for behavioral health care compared to medical-surgical care is high. According to a recent report, "Behavioral Health Parity—Pervasive Disparities in Access to In-Network-Care" by the Research Triangle Institute, in 2019-2021 "patients went out-of-network 3.5 times more often to see a behavioral health clinician than a medical/surgical clinician, 8.9 times more often to see a psychiatrist, 10.6 times more often to see a psychologist, 6.2 times more often for acute behavioral inpatient care, and 19.9 times more often for sub-acute behavioral inpatient care." While some may argue that high out-of-network usage is due to short staffing, the same report found that California has fewer primary care doctors per capita than mental health providers, "yet patients go out-of-network for primary care only 2.2% of the time compared to 15.3% for psychiatrists and 18.2% for psychologists."

According to the author, "Behavioral health providers are undercompensated compared to their medical-surgical peers, leading many to operate outside insurance networks. In California, only 55.4% of private practice psychotherapists and counselors accept insurance, making it difficult for residents to find in-network care. This lack of access imposes significant financial burdens:

families face average out-of-network bills of \$861 per episode, with some exceeding \$1,600, resulting in many going without care.

One major factor is the undervaluation of behavioral health providers by healthcare payors, which affects compensation. This bill aims to collect data for a study on compensation disparities between behavioral health and medical-surgical providers, leading to a report that can guide future interventions.”

The author continues, “When seeking behavioral health care, if consumers are unable to find in-network providers, they are then forced to pay out of pocket if they want to receive care. California’s underserved and marginalized communities are the least able to afford to pay for care out of pocket, and face among the greatest challenges securing in-network care, due to both the under-reimbursement and the absolute shortages of culturally and linguistically competent providers suited to meet their needs...

By studying the causes of California’s shortage of behavioral health providers who participate in insurance networks, California has an opportunity to rectify this shortage. Doing so will mean that members of underserved and marginalized communities will be better able to access affordable behavioral healthcare.”

Committee Comments

This bill tasks the DIR with the lead role in its implementation. Committee staff is not aware of DIR conducting a comparable worth study in the recent past. The DIR continues to struggle with short staffing and under-resourcing. Committee staff questions whether the department has the in-house expertise to conduct the study and recommends the author explore amending the bill in the future to authorize the DIR to contract out the study to a third party such as the UC Berkeley Labor Center.

Additionally, the author may wish to consider amending proposed Labor Code §194(a) to push out the effective date by six months or so to give the DIR and the coordinating departments time to develop the data reporting criteria.

Arguments in Support

The National Union of Healthcare Workers, sponsor of the bill, states, “Without transparent data on compensation disparities, policymakers lack the evidence base needed to effectively address this aspect of the behavioral health access crisis. AB 2511 would fill this critical information gap. The data gathered through AB 2511 would allow for:

1. An objective assessment of the extent and nature of compensation disparities.
2. Evidence-based policy development to address these disparities.
3. Better enforcement of existing parity laws.
4. Greater accountability for health systems and intermediaries in their compensation practices.

In the same way that comparable worth studies have proven effective in diagnosing and addressing unjustified differences in compensation between job classifications that have

historically been occupied primarily by incumbents of certain genders and racial and ethnic groups rather than others, a comparable worth study that examines disparities in compensation across the divide between behavioral healthcare and medical-surgical care can help identify the specific details of the widely acknowledged systematic undervaluation of behavioral health services and the work of the behavioral health professionals who provide them. This undervaluation of behavioral health services creates barriers to timely access to appropriate care, and these access barriers contribute to and exacerbate our state's behavioral health crisis.”

Arguments in Opposition

Kaiser Permanente is opposed to the bill and states, “AB 2511 is premised on a fundamentally flawed assumption that medical-surgical and behavioral health providers are similarly situated and therefore should be analyzed and compensated as if their roles, training, licensure, and responsibilities are interchangeable. These professions differ in educational pathways, clinical scope of practice, regulatory requirements, and patient care intensity. By requiring health plans and insurers to report all direct and indirect payments to both categories of providers, employees, and contractors alike, the bill ignores these critical distinctions and risks producing misleading comparisons that do not accurately reflect workforce realities or legitimate market differences across provider types.

The bill also presents an unprecedented intrusion into private compensation practices by singling out health care organizations for mandatory disclosure of wage and payment information tied to specific roles and occupations. Unlike other industries, health care organizations would be required to publicly report granular payment data that reflects complex staffing models, regional labor markets, and specialty-specific demands. This selective approach raises serious concerns about fairness, competitive harm, and the protection of sensitive compensation information, particularly where the data may be breached by bad actors, misinterpreted, or used outside its original intent.”

Prior Legislation

SB 747 (Wiener) of 2025 was substantially similar to AB 2511 but was subsequently gut and amended to address the issue of the deprivation of federal constitutional rights.

REGISTERED SUPPORT / OPPOSITION:

Support

National Union of Healthcare Workers (Sponsor)
California Alliance for Retired Americans
California Alliance of Child and Family Services
California Conference of Machinists
California Federation of Labor Unions, AFL-CIO
California One care Education Fund
California Pan - Ethnic Health Network
California Psychological Association
Courage California
Healthy California Now
National Association of Social Workers California Chapter
Steinberg Institute

The Kennedy Forum
Unite Here International Union, AFL-CIO

Opposition

Association of California Life & Health Insurance Companies
California Association of Health Plans
California Medical Association
Kaiser Permanente

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