Date of Hearing: April 21, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2511 (Ahrens) – As Introduced February 20, 2026

SUBJECT: Behavioral Health Provider Comparable Worth Study.

SUMMARY: Requires the Department of Industrial Relations (DIR) to conduct a comparable worth study to examine and compare compensation and reimbursement for behavioral health (BH) providers with compensation and reimbursement for similarly situated medical-surgical providers. Specifically, **this bill**:

1) Requires DIR , in consultation with the Department of Managed Health Care (DMHC), the Department of Insurance (CDI), Department of Health Care Access and Information (HCAI), and the Office of Health Care Affordability (OHCA), to conduct a comparable worth 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 plans and health insurers directly to BH providers and medical-surgical providers;

    b) Payments made by health plans and health insurers to intermediaries and health systems for BH services and medical-surgical services; and,

    c) Payments made by intermediaries and health systems to BH providers and medica-surgical providers, whether as employee compensation or as payments to independent contractors.

3) Requires DIR, in conducting the study, to:

    a) Develop a methodology for determining which BH provider roles are comparable to which medical-surgical provider roles, considering factors including, but not limited to, all of the following:

        i) Required skills and expertise;

        ii) Education requirements;

        iii) Specialized training;

        iv) Licensure and certification requirements; and,

        v) Similarity of working conditions.

    b) Identify which medical-surgical provider roles should be included in the study for comparison purposes so that each BH provider role is compared to at least one medical-surgical provider role;

c) Develop a table identifying sets of comparable BH provider roles and medical-surgical provider roles based on the methodology developed pursuant to a) above;

d) Collect and analyze compensation and reimbursement data for each provider role identified in the table developed pursuant to c) above, across each of the payment flows identified in 2); and,

e) Quantify any disparities in compensation and reimbursement between each set of comparable BH and medical-surgical provider roles, for each payment flow.

4) Requires each health plan and insurer to report the following to DIR:

a) With respect to payments made directly to providers: reimbursement rates for specific procedure codes and service categories for both BH services and medical-surgical services; the distribution of reimbursement rates, including the mean, median, 75th percentile, and 95th percentile, by provider type; total aggregate payments to BH providers and to medical-surgical providers; and,

b) With respect to payments made to intermediaries and health systems: the identity of each intermediary and health system with which the plan or insurer contracts for BH services or medical-surgical services; total payments made to each intermediary and health system for BH services and for medical-surgical services; 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.

5) Requires each intermediary and health system that contracts with health care service plans or health insurers for BH services or medical-surgical services to report the following to DIR:

a) With respect to payments received from a health plan or insurer: the identity of each plan and insurer from which the intermediary or system receives payment for BH services or medical-surgical services; total payments received from each plan or insurer for BH services and medical-surgical services; 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; and,

b) With respect to payments made to providers: for employed providers, compensation data including wages salaries and benefits, by provider type; for contracted providers, payment rates or amounts, by provider type, including per-service, per-session, or other payment structures; the distribution of payments to providers, including the mean, median 75th percentile, and 95th percentile, by provider type; total aggregate payments to BH providers and to medical-surgical providers.

6) Specifies that reporting in 5) only applies to intermediaries that employ or contract with 25 or more providers.

7) Requires DIR, in consultation with DMHC, CDI, HCAI and OHCA, and taking into account data that can be aggregated from information already required to be reported to all of the entities, to develop reporting requirements specifying the data elements to be reported, the format for reporting, and the deadlines for submission.

8) Requires DIR, DMHC, CDI, HCAI, and OHCA to protect the confidentiality of any proprietary or commercially sensitive information submitted pursuant to this chapter and shall publish only aggregated data that does not reveal information about individual entities or individual providers.

9) Subjects any entity that fails to comply with reporting requirements under this bill to a civil penalty of up to $10,000 per day for noncompliance.

10) Requires DIR to submit a report to the Legislature, containing the findings of the study. Requires the report to include the following:

    a) The methodology used to determine comparability between BH provider roles and medical-surgical provider roles;

    b) The medical-surgical provider roles identified for inclusion in the study;

    c) The table of comparable provider rolls sets developed;

    d) For each payment flow identified, a quantification of any disparities in compensation and reimbursement between each set of comparable BH and medical-surgical provider roles;

    e) An analysis of how compensation and reimbursement levels change as payments pass through intermediaries and health systems, including any differential treatment of BH services as compared to medical-surgical services; and,

    f) Identification of any discrepancies between data reported by payers and data reported by recipients regarding the same payment flows.

11) Requires DMHC, CDI, HCAI, and OHCA to cooperate with DIR and provide any data, information, and assistance necessary for DIR to conduct the study and prepare the report required by this bill, and, thereafter. Requires DIR to produce nonspecific aggregated data and only incorporate that nonspecific aggregated data into its report.

12) Permits DIR to adopt emergency regulations to implement this bill.

13) Defines a "BH 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.

14) Defines "compensation" to mean all forms of payment made to an employed provider for health care services, including wages, salaries, and benefits.

15) 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.

16) 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.

17) 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 BH services.

18) Defines "platform" to mean a digital health company or other technology-enabled entity that contracts with health care service plans, managed BH care organizations, health insurers, or health systems to provide access to health care providers.

19) Makes legislative findings and declarations on the BH crisis and undervaluation of BH providers.

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.]

2) Establishes DMHC to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 and CDI to regulate health insurers. [Health and Safety Code (HSC) § 1340, *et seq*., and Insurance Code (INS) § 106, *et seq*.]

3) Establishes HCAI in the California Health and Human Services Agency to expand equitable access to quality, affordable health care for all Californians through resilient facilities, actionable information, and the health workforce each community needs. [HSC § 127000, *et seq*.]

4) Establishes the California Health Care Quality and Affordability Act, which creates OHCA within HCAI. Identifies OHCA's three primary responsibilities: managing spending targets, monitoring system performance, and assessing market consolidation. Requires OHCA to collect, analyze, and publicly report data on total health care expenditures, and enforce spending targets set by a Health Care Affordability Board. [HSC § 127500, *et seq*.]

5) Requires every disability insurance policy and health plan that provides hospital, medical, or surgical coverage to provide coverage for medically necessary treatment of mental health (MH) and substance use disorders (SUDs), under the same terms and conditions applied to other medical conditions, as specified. [HSC § 1374.72 and INS § 10144.5]

6) Defines "medically necessary treatment of MH or SUD," including that the service or product is in accordance with generally accepted standards of MH or SUD care, clinically appropriate in terms of type, frequency, extent, site, and duration. [*Ibid.*]

7) Requires health plans or insurers, when medically necessary treatment of MH or SUD services are not available in network within the geographic and timely access standards set by law or regulation, 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 geographic and timely access standards. Requires "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 or insured within geographic and timely access standards. Requires the enrollee or insured to pay no more than the same cost-sharing that would be paid for the same covered services received from an in-network provider. [*Ibid*.]

FISCAL EFFECT: Unknown. This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, BH providers are undercompensated compared to their medical-surgical peers, leading many to operate outside insurance networks. The author states that in California, only 55.4% of private practice psychotherapists and counselors accept insurance, making it difficult for residents to find in-network care. The author continues that 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. The author argues that one major factor is the undervaluation of BH providers by healthcare payors, which affects compensation. The author concludes that this bill aims to collect data for a study on compensation disparities between BH and medical-surgical providers, leading to a report that can guide future interventions.

2) **BACKGROUND.**

   a) **BH disorders in California.**

      i) **SUD.** A 2022 publication from the California Health Care Foundation (CHCF), titled "Substance Use in California: Prevalence and Treatment" reported that substance use in California is widespread with over half of Californians over age 12 reporting using alcohol in the past month and 20% reporting using marijuana in the past year. According to the report, 9% of Californians have met the criteria for a SUD within the last year. Overdose deaths from both opioids and psychostimulants (such as amphetamines), are soaring. This issue, compounded by the increased availability of fentanyl, has resulted in a 10-fold increase in fentanyl related deaths between 2015 and 2019. This epidemic is disproportionately impacting American Indian and Alaskan Native Californians who have the highest rate of opioid overdose deaths, followed by white and Black Californians. According to the California Department of Public Health's Overdose Prevention Initiative, 7,847 opioid-related overdose deaths occurred in California in 2023. In the first two quarters of 2024, 2,975 opioid-related overdose deaths were recorded in California. In August 2024, Health Management Associates, with support of the CHCF published "Substance Use Disorder in California — a Focused Landscape Analysis" and found that a key barrier to accessing care for people with substance use disorders is the lack of access to housing and residential services.

      ii) **MH Disorders.** A 2022 publication from CHCF, titled "Mental Health in California" reported that nearly 1 in 7 California adults experience a mental illness, and 1 in 26 has a serious MH condition that makes it difficult to carry out daily activities. One in 14 children has an emotional disturbance that limits functioning in family, school, or community activities. According to the report, the prevalence of serious mental

illness varies by income, with the highest rates in adults and children in families with incomes below 100% of the federal poverty level.

A 2019 survey by the Substance Abuse and Mental Health Services Administration found nearly five million, or 16%, of Black Americans reported having a mental illness. However, only one in three Black adults who needs MH care receives it. Similarly, a 2021 study by the University of California Los Angeles Center for Health Policy Research found that almost half of Latino adults who had a perceived need for MH services experienced an unmet need for care.

b) **BH provider access.** According to HCAI, all 58 counties were projected to face a shortage across all BH roles in 2025, with the most severe shortages in the Northern & Sierra, Inland Empire, and San Joaquin Valley regions. Between associate level clinicians (such as associate professional clinical counselors), non-prescribing licensed clinicians (such as Licensed Clinical Social Workers and Licensed Marriage and Family Therapists), and psychiatrists, HCAI estimates that there is a statewide shortage of over 72,000 BH providers – a number which is projected to grow significantly by 2033.

This growing workforce shortage creates significant access gaps for patients seeking BH care. These gaps are further compounded by poor provider networks. The national advocacy organization Inseparable recently released a report focused on the scope of the national BH provider shortage, providing state-by-state snapshots on the issue. In California, Inseparable found that patients had to seek BH care out-of-network 5.8 times more often than they do for medical or surgical care. Inseparable cites low reimbursement rates and burdensome insurer practices as drivers that push BH providers out of insurance networks, leaving inadequate access to care for patients. In a report titled "The Behavioral Health Care Affordability Problem," the Center for American Progress (CAP) details that historically oppressed communities have faced the brunt of network inadequacy. CAP states that Black, Native, and low-income communities have experienced heightened levels of BH needs and have disproportionately struggled to access much-needed services.

3) **SUPPORT.** The National Union of Health Care Workers (NUHW) is sponsoring this bill, stating that it addresses a critical gap in our state's efforts to ensure true BH parity. NUHW notes that despite existing federal and state MH parity laws and regulations, significant disparities in compensation between BH providers and medical-surgical providers persist. NUHW argues that these disparities contribute to severe shortages of qualified BH professionals who are willing to participate in insurance networks, high turnover rates among BH professionals, and widespread difficulty in Californians accessing timely, appropriate, and affordable BH treatment. NUHW continues that without transparent data on compensation disparities, policymakers lack the evidence needed to effectively address this aspect of the BH access crisis. NUHW argues that 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 BH and medical-surgical care can help identify the specific details of the widely acknowledged systematic undervaluation of BH services and the work of the BH professionals who provide them. NUHW concludes that by requiring health plans, insurers, and other providers of

medical services to report their relevant compensation and reimbursement data, this bill creates transparency and accountability that can help illuminate the specifics of these compensation disparities, provide data to support future policy interventions, and ultimately address the difficulties patients face in accessing BH care.

4) **OPPOSED UNLESS AMENDED.** The California Hospital Association (CHA) and the California Chamber of Commerce (Chamber) are opposed to this bill unless it is amended to address their concerns. CHA states that directing cash-strapped state agencies and hospitals to study an already well-documented set of challenges is a waste of scarce resources. CHA and the Chamber note that this bill would create unnecessary and quadruplicate reporting obligations for hospitals. CHA and the Chamber further argue that health care data belongs in the Health & Safety Code, not Labor Code. CHA and the Chamber continue that important providers of BH care would be ignored and that comparing medical-surgical providers to BH providers would be a complex and potentially impossible task, limiting the report's usefulness to policymakers. For these reasons CHA and the Chamber are opposed unless it is amended to address these concerns.

5) **OPPOSITION.** The California Medical Association (CMA) is opposed to this bill, stating that it is premised on the assumption that medical-surgical providers and BH providers—including physicians and psychiatrists—are sufficiently comparable to be evaluated and compensated as though their roles or services are interchangeable. CMA continues that by comparing the compensation and reimbursement of psychiatrists to that of other physician specialties raises concerns, as there are inherent differences in specialized skills and nuanced clinical expertise that cannot be accurately captured through a standardized methodology. CMA notes that by requiring health plans and insurers to report all forms of compensation, the bill overlooks these important distinctions and risks producing misleading conclusions that fail to reflect these differences. Additionally, CMA is concerned that the reporting requirements would be particularly burdensome for independent physician or medical groups employing more than 25 providers. CMA notes that because these groups often function as intermediaries for health plans, they would be subject to the bill's onerous reporting requirement, which would require them to submit confidential information, including details about the contractual structure of their arrangements.

   The California Association of Health Plans (CAHP) and the Association of California Life and Health Insurance Companies (ACLHIC) are also opposed to this bill. CAHP and ACLHIC are concerned that the bill relies on the assumption that BH and medical-surgical providers are similarly situated for compensation purposes. CAHP and ACLHIC note that in practice, these professions differ in training, licensure, scope of practice, care settings, and workforce structure. CAHP and ACLHIC continue that treating them as directly comparable overlooks these important distinctions and risks producing conclusions that do not accurately reflect how care is delivered or how provider markets function. CAHP and ACLHIC argue that this bill would also require disclosure of sensitive and proprietary payment information unique to the health care sector, raising concerns about competitive harm and data security. CAHP and ACLHIC continue that at the same time, it would impose significant administrative burdens while generating data that may be incomplete or taken out of context. CAHP and ACLHIC further argue that this bill would impose significant administrative and compliance burdens on health plans, insurers, intermediaries, and health systems, while producing data that is likely to be incomplete and difficult to interpret. CAHP and ACLHIC

conclude that this bill would create new costs for both the private sector and the state without a clear connection to improved access to care, workforce.

6) **RELATED LEGISLATION.** AB 2551 (Elhawary) would require health plans and health insurers to collect data and report on the number of enrollees and insureds seeking out-of-network BG care. AB 2551 would expand existing licensing board reporting requirements to include whether a licensee and registrant contracts with a health plan or health insurer to provide services. AB 2551 is currently pending in the Assembly Appropriations Committee.

7) **PREVIOUS LEGISLATION. S**B 747 (Wiener), of 2025, as introduced was substantially similar to AB 2511 but was subsequently amended into a different subject matter.

REGISTERED SUPPORT / OPPOSITION:

Support

National Union of Healthcare Workers (sponsor)
California Alliance for Retired Americans
California Alliance of Child and Family Services
California Federation of Labor Unions, AFL-CIO
California OneCare Education Fund
California Psychological Association
Contra Costa Central Labor Council
Courage California
Fierce (Filipinx Igniting Engagement for Reimagining Collective Empowerment) Coalition
Healthy California Now
Inland Empire Labor Council, AFL-CIO
NASW California
National Association of Social Workers, California Chapter
Pilipino Workers Center of Southern California
San Diego and Imperial Counties Labor Council, AFL-CIO
Steinberg Institute
The Kennedy Forum
Therapists for Single Payer
UAW Region 6

Opposition

America's Physician Groups
Association of California Life & Health Insurance Companies
California Association of Health Plans
California Medical Association
Kaiser Permanente

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