

Date of Hearing: April 7, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2551 (Elhawary) – As Amended March 19, 2026

SUBJECT: Health care coverage.

SUMMARY: Requires health plans and health insurers to collect data and report on the number of enrollees and insureds seeking out-of-network behavioral health (BH) care. Expands existing licensing board reporting requirements to include whether a licensee and registrant contracts with a health plan or health insurer to provide services. Specifically, **this bill:**

- 1) Requires a health plan and health insurer to conduct an annual survey of all enrollees or insureds to assess all of the following:
 - a) Number and prevalence of enrollees seeking or accessing BH care services from out-of-network providers;
 - b) Total expenditures paid out-of-pocket by enrollees for out-of-network BH care services from out-of-network providers; and,
 - c) The reasons for seeking or accessing out-of-network providers and paying out-of-pocket for BH care services, including, but not limited to, lack of access to affordable, timely, geographically accessible, and culturally and linguistically competent care delivered in person or via telehealth.
- 2) Requires the annual survey to be optional for enrollees or insureds to complete.
- 3) Permits the health plan or health insurer to incorporate questions to fulfill these requirements into existing surveys.
- 4) Requires a health plan or health insurer to report survey findings to the Department of Managed Health Care (DMHC) and California Department of Insurance (CDI) on or before May 1, 2028 and annually thereafter.
- 5) Requires DMHC and CDI to adopt regulations establishing standard requirements and a survey tool for health plans and health insurers to use in order to comply with this bill. Requires the regulations to include standards and guidelines for the collection of member-level demographic data to more effectively assess and report disparities in the number and prevalence of individuals going out-of-network and paying out-of-pocket for BH care, and the total expenditures paid out-of-pocket, as specified. Requires regulations and standards to be finalized by July 1, 2027 and requires plans to utilize standards by October 1, 2027.
- 6) Requires DMHC and CDI to develop an annual report based on data submitted pursuant to this bill and DMHC's Annual Network Report submissions or CDI's health insurer network adequacy reporting of network and non-network BH provider requests and determinations.
- 7) Requires the Board of Registered Nursing, the Board of Vocational Nursing and Psychiatric Technicians, the Physician Assistant Board, and the Respiratory Board to collect data from their respective licensees and registrants on whether they contract with a health plan or health

insurer to provide services. Requires the type of health plan or health insurer, including commercial coverage, Medi-Cal, and Medicare, to be specified.

- 8) Requires all other healing arts boards under the Department of Consumer Affairs (DCA) to request the data specified in 6) above from their licensees or registrants.
- 9) Makes legislative findings and declarations on access to BH care, impacts on diverse communities, and prevalence of out-of-network care.
- 10) States that it is the intent of the legislature that this bill:
 - a) Requires health plans and health insurers to survey and publicly report the number and prevalence of enrollees or insureds going out-of-network for BH care, the total expenditures paid out-of-pocket by enrollees for out-of-network and in-network BH care services after copayments, coinsurance, and applicable deductibles are applied, and the reasons, including lack of access to affordable, timely, geographically accessible, and culturally and linguistically responsive care delivered in person or via telehealth; and,
 - b) Requires DMHC to develop an annual report that summarizes health plan survey findings on the prevalence of, and the reasons for, out-of-network utilization and out-of-pocket enrollee costs. Additionally, requires DMHC reports to include data already submitted on the number of enrollee requests for network and non-network BH providers and determinations submitted pursuant to existing reporting requirements.
- 11) Defines “culturally and linguistically competent care” as the ability of health care providers and systems to adhere to the National Standards for Culturally and Linguistically Appropriate Services in order to provide respectful, effective, and understandable care and services that honor diverse patient cultural health beliefs and practices, language needs, health literacy, and other communication needs of patients, as specified.
- 12) Defines “disparity” as variation in BH care access, utilization, and costs between population groups by age, geographic area, primary language, race, ethnicity, sex, gender identity, sexual orientation, and disability status.
- 13) Defines “member-level demographic data” as information specific to an individual enrollee that is self-reported by the enrollee about their own race, ethnicity, language, sex, gender identity, sexual orientation, disability status, and other characteristics.

EXISTING LAW:

- 1) 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.*]
- 2) 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]

- 3) 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.*]
- 4) 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.*]
- 5) Establishes the DCA within the Business, Consumer Services, and Housing Agency. [Business and Professions Code (BPC) §§ 100, *et seq.*]
- 6) Establishes various boards, bureaus, and other entities within the jurisdiction of the DCA. [BPC § 101]
- 7) Establishes “healing arts” boards under the jurisdiction of DCA, which includes the following entities:
 - a) Acupuncture Board;
 - b) Board of Behavioral Sciences;
 - c) State Board of Chiropractic Examiners;
 - d) Dental Board of California;
 - e) Dental Hygiene Board of California;
 - f) Medical Board of California;
 - g) California Board of Naturopathic Medicine;
 - h) California Board of Occupational Therapy;
 - i) California Board of Optometry;
 - j) Osteopathic Medical Board of California;
 - k) California State Board of Pharmacy;
 - l) Physical Therapy Board of California;
 - m) Physician Assistant Board;
 - n) Podiatric Medical Board of California;

- o) Board of Psychology;
 - p) Board of Registered Nursing;
 - q) Respiratory Care Board of California;
 - r) Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board;
 - s) Veterinary Medical Board; and,
 - t) Board of Vocational Nursing and Psychiatric Technicians. [BPC §§ 500, *et seq.*]
- 8) Requires the Board of Registered Nursing, the Board of Vocational Nursing and Psychiatric Technicians, the Physician Assistant Board, and the Respiratory Care Board of California to collect specified workforce data from their respective licensees and registrants for future workforce planning at least biennially, with data collected at the time of electronic license or registration renewal as applicable. [BPC § 502(a)(1)]
- 9) Provides that all other healing arts boards will request the specified workforce data for future workforce planning at least biennially, with data collected at the time of electronic license or registration renewal as applicable. [BPC § 502(a)(2)]

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

COMMENTS:

- 1) **PURPOSE OF THIS BILL.** According to the author, parity laws were supposed to guarantee that mental health care is treated the same as physical health care. The author states that's not happening. The author continues that constituents are still forced to go out of network and pay thousands out of pocket just to get the care they need. The author concludes this bill is about closing that gap and making sure insurance actually works for the people it's meant to serve.
- 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 1 in 3 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 the Department of Health Care Access and Information (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.

This bill aims to collect measurable data to understand the scope of out-of-network BH care in California, who it’s impacting, and what it’s costing.

- 3) **SUPPORT.** The California Pan-Ethnic Health Network (CPEHN) is sponsoring this bill, arguing that it lays critical groundwork for improvement in BH coverage and network adequacy for Californians covered by health insurance, especially communities of color and those with limited English proficiency. CPEHN notes that despite billions of dollars in state

investment in the public BH safety net and laws requiring public and commercial health plans to provide necessary care, too many Californians report struggling to access effective BH services. CPEHN continues that communities of color face particular challenges with access to care and report some of the lowest rates of utilization of MH services. For Californians who speak a language other than English, finding BH care that meets their needs is particularly daunting as stories collected by CPEHN demonstrate. CPEHN states that when health plans do not have enough providers to offer accessible care to their members, consumers are forced to wait for care, go without it, or go to out-of-network providers and pay out of pocket. That means paying twice since this care should already be covered by their health plan- and is already paid for with their premiums. CPEHN notes that nationwide estimates show adults aged 18 and over paid about \$15 billion in out-of-pocket expenses for BH treatment annually. Individuals seeking MH services are six times more likely to have to go out-of-network for care compared to other services, and in one-third of these cases, they bear the full cost themselves. CPEHN argues that additional data is needed at the national and state levels to understand why and how often these out-of-pocket care and expenses are incurred, and this bill will remedy that gap in knowledge. CPEHN concludes that understanding how often care is accessed outside of the insurer's network, why this occurs, and how much members pay for out-of-network care and in-network care after copayments, coinsurance, and applicable deductibles are applied, is critical to understanding existing gaps in care and the steps that must be taken to address them.

- 4) **OPPOSITION.** The California Association of Health Plans and Association of Life and Health Insurance Companies are opposed to this bill, stating that it would require new annual surveys and reporting on out-of-network behavioral health care, adding to existing oversight requirements, network adequacy standards, timely access rules, and ongoing reporting. The opposition continues that these additional mandates increase administrative costs without addressing the root causes of access challenges. The opposition argues that this bill oversimplifies why enrollees/insureds seek out-of-network behavioral health care. The opposition continues that in many cases, especially in preferred provider organization products, out-of-network use reflects plan design rather than a lack of access. In closed-network products, out-of-network care is only approved when specific criteria are met, and in those cases, member cost-sharing is already limited to in-network levels under existing law and regulations. The opposition notes that when members seek out-of-network care outside of these requirements, plans/insurers often have no visibility into the service or its cost unless a claim is submitted. As a result, the opposition argues it is unclear how plans/insurers would be able to accurately identify what enrollees/insureds to survey or reliably collect the information required under this bill. The opposition concludes that given the complexity of this issue, the Legislature may wish to consider a policy that preserves timely access to out-of-network care when necessary, protects consumers from excessive charges, and restores incentives for providers to participate in networks rather than one that simply adds an additional administrative burden to system.
- 5) **RELATED LEGISLATION.** AB 2011 (Hart) would codify federal Mental Health Parity and Addiction Equity Act (MHPAEA) regulations into state law. AB 2011 is currently pending in the Assembly Appropriations Committee.

6) PREVIOUS LEGISLATION.

- a) AB 1991 (Bonta), Chapter 369, Statutes of 2024, requires all healing arts boards under DCA to require their licensees or registrants who electronically renews their license or registration to provide to that board the licensee's or registrant's individual National Provider Identifier, if they have one.
- b) AB 133 (Committee on Budget), Chapter 143, Statutes of 2021, consolidated workforce data collection requirements and requires all healing arts boards to request, if not require, that data.
- c) AB 1236 (Ting) of 2021 would have consolidated workforce data collection requirements and required all healing arts boards to collect that data. AB 1236 was held on the inactive file of the Assembly Floor.
- d) AB 2704 (Ting) of 2020 would have consolidated workforce data collection requirements and required all healing arts boards to collect that data. AB 2704 was held in the Assembly Business and Professions Committee.
- e) AB 2102 (Ting), Chapter 420, Statutes of 2014, required four specified healing arts boards to collect and report specific demographic data related to its licensees.

REGISTERED SUPPORT / OPPOSITION:**Support**

California Pan - Ethnic Health Network (sponsor)
 A.B.L.E. Community Development Foundation
 AARP
 Access Reproductive Justice
 Access to Thrive, Inc.
 Anti Police-terror Project
 Asian Resources, Inc.
 Cal Voices
 California Alliance of Child and Family Services
 California Association of Alcohol and Drug Program Executives, Inc.
 California LGBTQ Health and Human Services Network
 Center for Empowering Refugees & Immigrants
 Children Now
 Disability Rights California
 Disability Voices United
 Empowering Pacific Islander Communities Fiscally Sponsored by Community Partners
 Health Access California
 Hillside Pasadena
 Imperial Valley Equity & Justice Coalition
 International Rescue Committee - Los Angeles
 Mental Health America of California
 Mighty Community Advocacy
 MILPA Collective
 National Health Law Program

National Union of Healthcare Workers
Queercasa
Refugee Enrichment and Development Association
Regional Pacific Islander Taskforce
Sacramento Area Congregation Together
San Diego Refugee Communities Coalition
Scope LA
South Asian Network
Southeast Asia Resource Action Center
The Children's Partnership
The East Oakland Collective
Transitions Clinic Network
United Women of East Africa Support Team
Youth Will

Opposition

Association of California Life & Health Insurance Companies
California Association of Health Plans

Analysis Prepared by: Riana King / HEALTH / (916) 319-2097