ASSEMBLY THIRD READING
AB 2551 (Elhawary)
As Amended March 19, 2026
Majority vote

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.

COMMENTS

BH disorders in California.

i) *Substance Use Disorders (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) *Mental Health (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.

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.

According to the Author
According to the author, parity laws were supposed to guarantee that MH 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.

Arguments in 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.

Arguments in 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 BH 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 BH 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.

FISCAL COMMENTS

According to the Assembly Committee on Appropriations:

1) The Department of Managed Health Care (DMHC) estimates costs of approximately $677,000 in fiscal year (FY) 2026-27; $1.16 million in FY 2027-28, $1.13 million each year in FYs 2028-29 and 2029-30, and $1.11 million in FY 2030-31 and annually thereafter (Managed Care Fund (MCF)). These costs include three to four additional staff positions to promulgate regulations; prepare an annual network report; meet with and otherwise communicate with stakeholders; and conduct legal, clinical, and statistical research. Costs also include contracts with consultants for statistical analyses to determine health plan compliance, among other activities and expenses. DMHC notes that, generally, a $1 million increase to the MCF could result in an increase of $0.02 per enrollee per year on assessments to full-service health plans and $0.01 for specialized health plans.

2) Costs to the California Department of Insurance of an unknown amount, potentially in the hundreds of thousands of dollars per year, to prepare the report, develop regulations and guidelines and communicate with insurers, and assess compliance (Insurance Fund).

3) The Department of Consumer Affairs (DCA) reports the healing arts boards anticipate minimal to no fiscal impact, as existing systems and processes can be used to collect the

required information. DCA′s Office of Information Services estimates updating survey questions to include data collection would cost $15,000, which is absorbable.

VOTES

ASM HEALTH: 16-0-0
YES: Bonta, Chen, Addis, Aguiar-Curry, Ahrens, Caloza, Carrillo, Mark González, Johnson, Patel, Patterson, Rogers, Sanchez, Schiavo, Sharp-Collins, Stefani

ASM APPROPRIATIONS: 15-0-0
YES: Wicks, Hoover, Aguiar-Curry, Calderon, Caloza, Dixon, Fong, Mark González, Krell, Pacheco, Pellerin, Sharp-Collins, Solache, Ta, Tangipa

UPDATED

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