Board of Behavioral Sciences

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: AB 2511 **VERSION:** INTRODUCED FEBRUARY 20, 2026

AUTHOR: AHRENS **SPONSOR:** NATIONAL UNION OF HEALTHCARE WORKERS

RECOMMENDED POSITION: SUPPORT

SUBJECT: BEHAVIORAL HEALTH PROVIDER COMPARABLE WORTH STUDY

Summary:

This bill would require the Department of Industrial Relations to conduct a study comparing the compensation and reimbursement of behavioral health providers with that of similarly situated medical-surgical providers.

Existing Law:

1) Establishes the state's Department of Industrial Relations, which functions to foster and develop the welfare of wage earners in California, improve their working conditions, and advance their opportunities for profitable employment. (Labor Code (LC) §§50, 50.5)

2) Establishes the Department of Health Care Access and Information to serve as the central source of health care workforce and educational data in the state. This department is tasked with reporting health care education and employment trends, current supply and demand for health care workers in the state and recommending state policy needed to address workforce shortages and distribution. (Health and Safety Code (HSC) §§ 128050, 128052)

3) Requires healing arts boards under the Department of Consumer Affairs (DCA) to request specified workforce data from their licensees and registrants at renewal for future workforce planning. The requested data includes area of specialty, location of practice, type of practice site, and spoken languages. The data is provided quarterly to the Department of Health Care Access and Information. (Business and Professions Code (BPC) §502)

This Bill:

1) Requires the Department of Industrial Relations to conduct a comparable worth study to compare compensation and reimbursement of behavioral health providers with that of similarly situated medical-surgical providers. (LC §191(a))

2) Defines a "behavioral health provider" as specified licensed professional who provide mental health or substance use disorder treatment, including LCSWs, LMFTs, and LPCCs. Defines a "medical-surgical provider" as a physician, physician assistant, nurse practitioner, registered nurse or other licensed or certified health care professionals who do not provide behavioral health services. (LC §190(a) and (i))

3) Requires the study to analyze compensation and reimbursement payments made by health care service plans/insurers directly to behavioral health providers and medical-surgical providers, payments made by health care service plans/insurers to intermediaries and health systems for behavioral health services and medical-surgical services, and payments made by intermediaries and health systems to behavioral health providers and medical-surgical providers. (LC §191(b))

4) For purposes of the study, requires a methodology for determining which behavioral health provider roles are comparable to which medical-surgical provider roles, considering factors such as education, requirements, licensing requirements, and specialized training. (LC §191(c))

5) Requires each health care service plan, health insurer, intermediaries, and health system to report specific data to the Department of Industrial Relations for the study, including: (LC §§ 192, 193)

a. Reimbursement rates for specific procedure codes for behavioral health services and medical-surgical services;

b. The distribution of reimbursement rates;

c. Total aggregate payment to behavioral health providers and medical-surgical providers.

d. Compensation data made to employed providers by an intermediary or a health system, including wages, salaries and benefits by provider type.

6) Requires the Department of Industrial Relations to submit a report of the study findings to the Legislature by January 1, 2028. (LC §196)

Comment:

1) **Author's Intent.** In the intent language for the bill, the author notes that California is facing a severe behavioral health crisis largely driven by inadequate access to care, in part by due to insurers' longstanding undervaluation and underpayment of behavioral health services. They state that research shows this results in lower provider compensation, higher out-of-network use, and payment flows through intermediaries that may contribute to the disparities.

They note that the undervaluation of behavioral health care results in reimbursement rate disparities, driving behavioral health professionals away from accepting insurance. (See **Link 1** below).

The author is pursuing this study to identify where and why behavioral health professionals are underpaid, so that this information can inform where policy changes are needed to address the issue.

2) **Previous Legislation.** AB 133 (Chapter 143, Statutes of 2021) required DCA healing arts boards to request specified workforce demographic data from their licensees and registrants at the time of license or registration renewal, and to provide that information to the Department of Health Care Access and Information.

3) **Recommended Position.** At its April 17, 2026 meeting, the Policy and Advocacy Committee recommended that the Board take a support position on this bill.

4) **Support and 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

5) History.

04/09/26 From committee: Do pass and re-refer to Com. on HEALTH. (Ayes 5. Noes 2.) (April 8). Re-referred to Com. on HEALTH.
04/09/26 Coauthors revised.
03/16/26 Referred to Coms. on L. & E. and HEALTH.
02/21/26 From printer. May be heard in committee March 23.
02/20/26 Read first time. To print.

6) Links.

Link 1: Jane M Zhu, Aine Huntington, Simon Haeder, Courtney Wolk, K John McConnell, Insurance acceptance and cash pay rates for psychotherapy in the US, *Health Affairs Scholar*, Volume 2, Issue 9, September 2024, qxae110, https://doi.org/10.1093/haschl/qxae110

ASSEMBLY BILL No. 2511

Introduced by Assembly Member Ahrens
(Coauthor: Assembly Member Pellerin)

February 20, 2026

An act to add Chapter 9 (commencing with Section 190) to Division 1 of the Labor Code, relating to employment.

legislative counsel's digest

AB 2511, as introduced, Ahrens. Behavioral Health Provider Comparable Worth Study.

Existing law establishes the Department of Industrial Relations in the Labor and Workforce Development Agency and provides that one of the functions of the department is to foster, promote, and develop the welfare of the wage earners of California, to improve their working conditions, and to advance their opportunities for profitable employment.

This bill would require the department, in consultation with the Department of Managed Health Care, the Department of Insurance, the Department of Health Care Access and Information, and the Office of Health Care Affordability, 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. The bill would require the study to analyze compensation and reimbursement across specified payment flows, including payments made by health care service plans and health insurers directly to behavioral health providers and medical-surgical providers, and payments made to intermediaries and health systems for behavioral health services and medical-surgical services. The bill would require the department to take certain actions in conducting the study,

including developing a methodology for determining which behavioral health provider roles are comparable to which medical-surgical provider roles.

The bill would require a health care service plan or health insurer to report certain data to the department with respect to payments made directly to providers and payments made to intermediaries and health systems. The bill would also require specified intermediaries and health systems to report certain data to the department relating to payments received and payments made. The bill would make an entity that fails to comply with the reporting requirements subject to civil penalty, as prescribed.

The bill would require the department and the other state entities listed above to protect the confidentiality of any propriety or commercially sensitive information submitted pursuant to the bill, as provided. The bill would require the department, on or before January 1, 2028, to submit a report to the Legislature containing the findings of the study.

Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. This act shall be known and may be cited as the Behavioral Health Provider Comparable Worth Study Act.

SEC. 2. The Legislature finds and declares all of the following:

(a) California faces a behavioral health crisis that threatens the well-being, safety, and economic security of millions of its residents.

(b) This crisis is in significant measure the result of the difficulty many Californians face in accessing behavioral health services.

(c) Access problems are driven in part by systemic undervaluation of behavioral health care by health insurers, resulting in direct compensation to behavioral health providers and reimbursement to intermediaries that are insufficient to

incentivize these providers to participate in insurance networks in numbers large enough to meet patients' needs.

(d) Research demonstrates that patients go out of network significantly more often to see behavioral health providers than medical-surgical providers, imposing substantial financial burdens on individuals and families seeking care.

(e) There is evidence that health insurers and other purchasers of health care services systematically compensate behavioral health providers at lower rates than similarly situated providers of medical-surgical care, even when the two groups share similar levels of education, licensure requirements, and patient care responsibilities.

(f) The flow of payments from health plans to behavioral health providers often passes through intermediaries, including specialty plans, platforms, provider groups, and health systems, and the terms of these arrangements may contribute to compensation disparities experienced by those providers.

(g) A comprehensive, data-driven study examining compensation and reimbursement across different payment flows is necessary to identify where disparities originate and to inform appropriate legislative action.

SEC. 3. Chapter 9 (commencing with Section 190) is added to Division 1 of the Labor Code, to read:

Chapter 9. Behavioral Health Provider Comparable Worth Study

190. For purposes of this chapter, the following definitions apply:

(a) "Behavioral health provider" means 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.

(b) "Compensation" means all forms of payment made to an employed provider for health care services, including wages, salaries, and benefits.

(c) "Department" means the Department of Industrial Relations.

(d) "Health care service plan" has the same meaning as defined in Section 1345 of the Health and Safety Code.

(e) "Health insurer" means an insurer licensed to provide health insurance in this state pursuant to the Insurance Code.

(f) "Health system" means 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.

(g) "Intermediary" means 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. "Intermediary" does not include a health system.

(h) "Managed behavioral health care organization" means an entity, such as a specialized health plan, mental health plan, or delegate, to which a health care service plan or health insurer has delegated responsibility for arranging, managing, or administering mental health or substance use disorder services."

(i) "Medical-surgical provider" means 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.

(j) "Platform" means 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.

(k) "Reimbursement" means payment made by a health care service plan or health insurer for health care services, whether paid directly to a provider, to a health system, or to an intermediary.

191. (a) The department, in consultation with the Department of Managed Health Care, the Department of Insurance, the Department of Health Care Access and Information, and the Office of Health Care Affordability, shall 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.

(b) The study shall analyze compensation and reimbursement across the following payment flows:

(1) Payments made by health care service plans and health insurers directly to behavioral health providers and medical-surgical providers.

(2) Payments made by health care service plans and health insurers to intermediaries and health systems for behavioral health services and medical-surgical services.

(3) 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.

(c) In conducting the study, the department shall do all of the following:

(1) 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:

(A) Required skills and expertise.

(B) Education requirements.

(C) Specialized training.

(D) Licensure and certification requirements.

(E) Similarity of working conditions.

(2) Identify which medical-surgical provider roles should be included in the study for comparison purposes so that each behavioral health provider role is compared to at least one medical-surgical provider role.

(3) Develop a table identifying sets of comparable behavioral health provider roles and medical-surgical provider roles based on the methodology developed pursuant to paragraph (1).

(4) Collect and analyze compensation and reimbursement data for each provider role identified in the table developed pursuant to paragraph (3), across each of the payment flows identified in subdivision (b).

(5) Quantify any disparities in compensation and reimbursement between each set of comparable behavioral health and medical-surgical provider roles, for each payment flow.

192. Each health care service plan and health insurer shall report to the department the data specified in this section.

(a) With respect to payments made directly to providers, each health care service plan and health insurer shall report all of the following:

(1) Reimbursement rates for specific procedure codes and service categories for both behavioral health services and medical-surgical services.

(2) The distribution of reimbursement rates, including the mean, median, 75th percentile, and 95th percentile, by provider type.

(3) Total aggregate payments to behavioral health providers and to medical-surgical providers.

(b) With respect to payments made to intermediaries and health systems, each health care service plan and health insurer shall report all of the following:

(1) The identity of each intermediary and health system with which the plan or insurer contracts for behavioral health services or medical-surgical services.

(2) Total payments made to each intermediary and health system for behavioral health services and for medical-surgical services.

(3) 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.

193. (a) Except as provided in subdivision (d), each intermediary and health system that contracts with health care service plans or health insurers for behavioral health services or medical-surgical services shall report to the department the data specified in this section.

(b) With respect to payments received from health care service plans and health insurers, each intermediary and health system shall report all of the following:

(1) 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.

(2) Total payments received from each health care service plan and health insurer for behavioral health services and for medical-surgical services.

(3) 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.

(c) With respect to payments made to providers, each intermediary and health system shall report all of the following:

(1) For employed providers, compensation data including wages, salaries, and benefits, by provider type.

(2) For contracted providers, payment rates or amounts, by provider type, including per-service, per-session, or other payment structures.

(3) The distribution of payments to providers, including the mean, median, 75th percentile, and 95th percentile, by provider type.

(4) Total aggregate payments to behavioral health providers and to medical-surgical providers.

(d) This section only applies to an intermediary that employs or contracts with 25 or more providers.

194. (a) The department, in consultation with the Department of Managed Health Care, the Department of Insurance, the Department of Health Care Access and Information, and the Office of Health Care Affordability, and taking into account data that can be aggregated from information already required to be reported to all of the entities enumerated in this subdivision, shall develop reporting requirements specifying the data elements to be reported pursuant to Sections 192 and 193, the format for reporting, and the deadlines for submission.

(b) The department, the Department of Managed Health Care, the Department of Insurance, the Department of Health Care Access and Information, and the Office of Health Care Affordability shall 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.

195. An entity that fails to comply with the reporting requirements established pursuant to this chapter 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 department.

196. (a) On or before January 1, 2028, the department shall submit a report to the Legislature, in compliance with Section 9795 of the Government Code, containing the findings of the study conducted pursuant to this chapter.

(b) The report shall include all of the following:

(1) The methodology used to determine comparability between behavioral health provider roles and medical-surgical provider roles.

(2) The medical-surgical provider roles identified for inclusion in the study pursuant to paragraph (2) of subdivision (c) of Section 191.

(3) The table of comparable provider rolls sets developed pursuant to paragraph (3) of subdivision (c) of Section 191.

(4) For each payment flow identified in subdivision (b) of Section 191, a quantification of any disparities in compensation and reimbursement between each set of comparable behavioral health and medical-surgical provider roles.

(5) 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.

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

197. The Department of Managed Health Care, the Department of Insurance, the Department of Health Care Access and Information, and the Office of Health Care Affordability shall cooperate with the department and provide any data, information, and assistance necessary for the department to conduct the study and prepare the report required by this chapter, and, thereafter, the department shall produce nonspecific aggregated data and only incorporate that nonspecific aggregated data into its report.

198. The department may adopt regulations to implement this chapter. Any regulations adopted pursuant to this section shall be adopted as emergency regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. The adoption of emergency regulations pursuant to this section shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare.

SEC. 4. The Legislature finds and declares that Section 3 of this act, which adds Chapter 9 (commencing with Section 190) to Division 1 of the Labor Code, imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of

Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

Data on the compensation of behavioral health employees and medical-surgical employees to be reported to the Department of Industrial Relations is necessary to understand and address compensation disparities between those employees and to promote increased access for Californians to behavioral health care. The limitation on access to this data is necessary to avert unintended interference in health care market pricing mechanisms.

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