BBS
Board of Behavioral Sciences

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: **AB 2551** **VERSION:** **AMENDED MARCH 19, 2026**

AUTHOR: **ELHAWARY** **SPONSOR:** **CALIFORNIA PAN-ETHNIC HEALTH NETWORK**

RECOMMENDED POSITION: SUPPORT

SUBJECT: **HEALTH CARE COVERAGE**

Summary: This bill seeks to gather information on the prevalence of individuals going out-of-network and paying out-of-pocket for behavioral health care, and the reasons behind them doing so.

Existing Law:

1) Requires every health care service plan or disability insurance policy that provides hospital, medical or surgical coverage to also provide coverage for medically necessary treatment of mental health and substance use disorders under the same terms and conditions applied to other medical conditions. (Health and Safety Code (HSC) §1374.72(a), Insurance Code (IC) §10144.5(a))

2) The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that requires health plans that offer mental health or substance use disorder benefits to ensure that financial requirements (e.g., copays and deductibles) and treatment limitations (e.g., visit limits) are no more restrictive than those applied to medical/surgical benefits. MHPAEA applies directly to most employer-sponsored group health plans with more than 50 employees.

3) Requires all DCA healing arts boards to biennially request certain workforce data from its licensees and registrants at the time of electronic renewal for future workforce planning. (BPC §502(a))

4) Specifies the data to be collected, including the following (BPC §502(b)):

- **a)** City, county, and zip code of practice;
- **b)** Area of practice or specialty;
- **c)** Anticipated year of retirement;
- **d)** Gender or gender identity;

e) Languages spoken;

f) Race or ethnicity;

g) Type of employer or primary practice site;

h) Sexual orientation;

i) Disability status

5) Requires that the above information be kept confidential and only released in aggregate form. Also specifies that a licensee is not required to report any of the above information to the Board. (BPC §502(c), (f))

6) Requires each board, or DCA on a board's behalf, to provide the data to the Department of Health Care Access and Information (HCAI) quarterly. (BPC §502(e))

7) Establishes HCAI to serve as the central source of health care workforce and educational data in the state, responsible for the collection, analysis, and distribution of information on the educational and employment trends for health care occupations in the state. It is tasked to work with licensing boards to collect available data on supply, geographic distribution, diversity, and demand for health care workers. (Health and Safety Code (HSC) §§128050, 128051)

This Bill:

1) Requires DCA healing arts boards to request, in the biennial survey of licensees and registrants, information on whether the licensee or registrant is a contracted provider with a health insurer, either individually or through employment, and the types of insurers they provide services for (such as commercial coverage, Medi-Cal, and Medicare). (BPC §502(b)(15))

2) Requires health care service plans and insurers to conduct an annual, optional survey of its enrollees to assess the following (HSC §1374.199, Insurance Code (IC) §10127.22):

a. Number and prevalence of enrollees seeking or accessing behavioral health care from out-of-network providers.

b. Expenditures paid out-of-pocket by enrollees for out-of-network and in-network behavioral health care after copayments, coinsurance, and deductibles.

c. The reasons for seeking out-of-network behavioral health care providers and paying them out-of-pocket, such as lack of access to affordable, timely, geographically accessible, and culturally and linguistically competent care.

3) Requires the survey findings to be reported to the Department of Managed Care and the Department of Insurance annually and requires those departments to produce an annual report. (HSC §1374.199, IC §10127.22)

4) Requires the Department of Managed Care and the Department of Insurance to adopt regulations establishing standard requirements and a survey tool for health plans to use to collect this information, in order to effectively assess and report disparities in the number and prevalence of enrollees and their reasons for going out-of-network and paying out-of-pocket for behavioral health care services. This must include identifying disparities for smaller, historically disadvantaged populations. (HSC §1374.199, IC §10127.22)

Comment:

1) **Author's Intent.** The author is seeking to increase transparency about how many people go out-of-network to access behavioral health care. In their factsheet for this bill, the author's office states the following:

   "Access to behavioral health care remains a crisis in California and across the country. Despite billions of dollars in public investment and updated laws requiring health care service plans and insurers to provide necessary care, many Californians still report difficulty accessing effective behavioral health services. Communities of color face particular challenges in accessing care and report some of the lowest rates of mental health service use. Californians who speak a language other than English, LGBTQIA+ individuals, and Black, Indigenous, and People of Color (BIPOC) communities face additional barriers that make equitable access even harder."

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

3) **Previous Legislation.**

   - SB 855 (Chapter 151, Statutes of 2020) expanded upon California's existing mental health parity act to require health plans and insurers to cover all medically necessary treatment of mental health and substance use disorders under the same terms and conditions applied to other medical conditions.

   - AB 88 (Chapter 534, Statutes of 1999) required health plans and insurers to provide coverage for the diagnosis and medically necessary treatment of severe mental illness (for persons of any age), and for serious emotional disturbances of a child under the same terms and conditions applied to other medical conditions.

4) **Support and 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
- Hillsides 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

5) History

04/08/26 From committee: Do pass and re-refer to Com. on APPR. (Ayes 16. Noes 0.) (April 7). Re-referred to Com. on APPR.
03/23/26 Re-referred to Com. on HEALTH.
03/19/26 From committee chair, with author's amendments: Amend, and re-refer to Com. on HEALTH. Read second time and amended.
03/19/26 Referred to Com. on HEALTH.
02/21/26 From printer. May be heard in committee March 23.
02/20/26 Read first time. To print.

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AMENDED IN ASSEMBLY MARCH 19, 2026

california legislature—2025–26 regular session

ASSEMBLY BILL No. 2551

Introduced by Assembly Member Elhawary

February 20, 2026

An act *to amend Section 502 of the Business and Professions Code, to add Section 1374.199 to the Health and Safety Code, and to add Section 10127.22 to the Insurance Code,* relating to health care coverage.

legislative counsel's digest

AB 2551, as amended, Elhawary. ~~Behavioral health~~ *Health* care coverage.

~~Existing~~

(1) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health ~~Care.~~ *Care, and makes a willful violation of the act a crime.* Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of mental health and substance use disorders, as defined, under the same terms and conditions applied to other medical conditions.

~~This bill would express the intent of the Legislature to enact legislation to require health care service plans and health insurers to survey and publicly report the percentage of enrollees or insureds going in network or out of network for behavioral health care, among other things. The bill would also make related findings and declarations.~~

This bill would require health care service plans and health insurers to conduct an annual survey to assess the number and prevalence of enrollees or insureds seeking or accessing behavioral health care services from out-of-network providers, the total expenditures paid out-of-pocket by enrollees and insureds for out-of-network and in-network behavioral health care services, as specified, and the reasons for seeking out-of-network behavioral health services. The bill would require the annual survey to be optional for enrollees or insureds. The bill would require health care service plans and health insurers to report survey findings to the departments on or before May 1, 2028, and annually thereafter. The bill would require the departments to adopt regulations establishing standard requirements and a survey tool, as specified. The bill would require the departments to develop annual reports based on the annual survey and other data, as specified. Because a willful violation of these requirements by a health care service plan would be a crime, this bill would impose a state-mandated local program.

(2) Existing law requires specified boards, including the Board of Registered Nursing and the Respiratory Care Board of California, to collect certain workforce data from their respective licensees and registrants for future workforce planning at least biennially. Existing law requires other specified boards that regulate healing arts licensees or registrants to request workforce data from their respective licensees and registrants for future workforce planning at least biennially. Existing law requires the workforce data collected or requested to include specified information, including, among others, the type of employer or classification or primary practice site, as specified. Existing law prohibits a licensee or registrant from being required to provide the information as a condition for license or registration renewal, and prohibits licensees or registrants from being subject to discipline for not providing the information.

This bill would require the information collected or requested by boards to include whether a licensee or registrant is a contracted provider and the types of health care coverage under which contracted services are provided.

(3) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

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

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

1 SECTION 1. The Legislature finds and declares all of the
2 following:
3 (a) Access to behavioral health care is at a crisis point in
4 California and the nation. Despite billions of dollars in state
5 investment in the public mental health safety net and updated laws
6 requiring health care service plans and health insurers to provide
7 necessary care, too many Californians report struggling to access
8 effective behavioral health services.
9 (b) Communities of color face particular challenges with access
10 to care and report some of the lowest rates of utilization of mental
11 health services.
12 (c) For Californians who speak a language other than English,
13 finding behavioral health care that meets their needs is particularly
14 daunting.
15 (d) LGBTQIA+ individuals within Black, Indigenous, and
16 People of Color (BIPOC) communities, in particular, face distinct
17 challenges that compound the barriers to equitable mental health
18 care. Navigating the health system to find and access a culturally
19 affirming provider can feel like an impossibility, forcing many to
20 seek care outside of their plan or policy or to forgo care entirely
21 because they cannot afford to pay out of pocket.
22 (e) Since passage of the federal Patient Protection and
23 Affordable Care Act, health care service plans and health insurers
24 have been required to provide medically necessary mental health
25 services for their enrollees and insureds. Additionally, in 2020,
26 the Legislature took action to ensure strong enforcement of the
27 Paul Wellstone and Pete Domenici Mental Health Parity Addiction
28 Equity Act of 2008, which requires health care service plan
29 contracts and health insurance policies to provide mental health
30 and substance use disorder coverage that is no more restrictive or
31 costly than coverage for physical health for medical or surgical
32 conditions.

(f) California consumers are increasingly forced to go out of network to access behavioral health care. Nationally, consumers pay $15 billion in out-of-pocket expenses for treatment for mental health disorders.

(g) Individuals seeking mental health 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.

(h) Behavioral health out-of-pocket spending rose at double the rate by 2022 of other medical costs for children, causing major family financial strain.

(i) Despite legislation, Department of Managed Health Care behavioral health investigations have found contracted providers are increasingly dissatisfied with network access. Low reimbursement rates, onerous health care service plan processes for authorizing payment, and burdensome contracting terms are the dominant reasons for the shortage of in-network mental health providers. Though the number of therapists who accept health care coverage isn't tracked by a single organization, one estimate suggests 42 percent of therapists in California don't accept health care coverage at all.

(j) Without the financial help of health care coverage, clients pay an average of $130 out of pocket per session or higher in major cities.

SEC. 2. It is the intent of the Legislature ~~to enact legislation to~~ *that this act* do all of the following:

(a) Require health care service plans and health insurers to survey and publicly report the ~~percentage of~~ *number and prevalence of* enrollees or insureds going ~~in network or~~ out of network for behavioral health ~~care and why,~~ *care, the total expenditures paid out-of-pocket by enrollees for out-of-network and in-network behavioral health 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.~~ *care delivered in person or via telehealth.*

~~(b) Require health care service plans and health insurers to conduct a cultural competency and health equity assessment of their enrollees or insureds, including identifying disparities among the enrollee or insured population by age, race, culture, ethnicity,~~

~~sexual orientation, gender identity, income level, and geographic location, amongst other categories. As part of that assessment, plans and insurers would develop and implement comprehensive and effective training and programs for staff and participating providers and an evaluation and demonstration of how the assessment is being used to improve health outcomes, and reduce or eliminate disparities by understanding the challenges faced by enrollees or insureds.~~

(b) Require the Department of Managed Health Care 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, reports would include data already submitted on the number of enrollee requests for network and nonnetwork behavioral health providers and determinations submitted pursuant to existing reporting requirements.

(c) Add ~~a~~ *an optional* question on licensing renewal forms ~~stating whether or not~~ *for* providers of the healing arts *to state whether they* are currently contracting with a *health care service* plan or *health* insurer and the type of plan or insurer so California regulators can more readily monitor trends in provider contracting by region, language spoken, and provider type, amongst other categories.

SEC. 3. Section 502 of the Business and Professions Code is amended to read:

502. (a) Notwithstanding any other law, both of the following apply:

(1) The Board of Registered Nursing, the Board of Vocational Nursing and Psychiatric Technicians of the State of California, the Physician Assistant Board, and the Respiratory Care Board of California shall collect workforce data from their respective licensees and registrants as specified in subdivision (b) for future workforce planning at least biennially. The data shall be collected at the time of electronic license or registration renewal for those boards that utilize electronic renewals for licensees or registrants.

(2) All other boards that are not listed in paragraph (1) that regulate healing arts licensees or registrants under this division shall request workforce data from their respective licensees and registrants as specified in subdivision (b) for future workforce planning at least biennially. The data shall be requested at the time

of electronic license or registration renewal for those boards that utilize electronic renewals for licensees or registrants.

(b) In conformance with specifications under subdivision (d), the workforce data collected or requested by each board about its licensees and registrants shall include, at a minimum, all of the following information:

(1) Anticipated year of retirement.

(2) Area of practice or specialty.

(3) City, county, and ZIP Code of practice.

(4) Date of birth.

(5) Educational background and the highest level attained at time of licensure or registration.

(6) Gender or gender identity.

(7) Hours spent in direct patient care, including telehealth hours as a subcategory, training, research, and administration.

(8) Languages spoken.

(9) National Provider Identifier.

(10) Race or ethnicity.

(11) Type of employer or classification of primary practice site among the types of practice sites specified by the board, including, but not limited to, clinic, hospital, managed care organization, or private practice.

(12) Work hours.

(13) Sexual orientation.

(14) Disability status.

(15) (A) Whether the licensee or registrant is a contracted provider with a health care service plan or health insurer to provide services, including through an individual contract or through employment with an organization that contracts with a health care service plan or health insurer.

(B) Type of health care service plans or health insurers under which contracted services are provided, including commercial coverage, Medi-Cal, and Medicare.

(c) Each board shall maintain the confidentiality of the information it receives from licensees and registrants under this section and shall only release information in an aggregate form that cannot be used to identify an individual other than as specified in subdivision (e).

(d) The Department of Consumer Affairs, in consultation with the Department of Health Care Access and Information, shall

specify for each board subject to this section the specific information and data that will be collected or requested pursuant to subdivision (b). The Department of Consumer Affairs' identification and specification of this information and data shall be exempt until June 30, 2023, from the requirements of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(e) Each board, or the Department of Consumer Affairs on its behalf, shall, beginning on July 1, 2022, and quarterly thereafter, provide the individual licensee and registrant data it collects pursuant to this section to the Department of Health Care Access and Information in a manner directed by the Department of Health Care Access and Information, including license or registration number and associated license or registration information. The Department of Health Care Access and Information shall maintain the confidentiality of the licensee and registrant information it receives and shall only release information in an aggregate form that cannot be used to identify an individual.

(f) A licensee or registrant shall not be required to provide the information listed in subdivision (b) as a condition for license or registration renewal, and licensees or registrants shall not be subject to discipline for not providing the information listed in subdivision (b).

(g) This section does not alter or affect mandatory reporting requirements for licensees or registrants established pursuant to this division, including, but not limited to, Sections 1715.5, 1902.2, 2425.3, and 2455.2.

SEC. 4. Section 1374.199 is added to the Health and Safety Code, to read:

1374.199. (a) (1) A health care service plan shall conduct an annual survey of all enrollees in order to assess all of the following:

(A) Number and prevalence of enrollees seeking or accessing behavioral health care services from out-of-network providers.

(B) Total expenditures paid out-of-pocket by enrollees for out-of-network behavioral health care services and in-network behavioral health care services after copayments, coinsurance, and applicable deductibles are applied.

1 *(C) The reasons for seeking or accessing out-of-network*
2 *providers and paying out-of-pocket for behavioral health care*
3 *services, including, but not limited to, lack of access to affordable,*
4 *timely, geographically accessible, and culturally and linguistically*
5 *competent care delivered in person or via telehealth.*
6 *(2) The annual survey shall be optional for enrollees to*
7 *complete.*
8 *(3) To the extent practicable, a health care service plan may*
9 *incorporate questions to fulfill these requirements into enrollee*
10 *surveys already conducted by the plan.*
11 *(4) A health care service plan shall report survey findings to*
12 *the department on or before May 1, 2028, and annually thereafter.*
13 *(b) (1) In implementing this section, the department shall*
14 *develop and adopt regulations establishing standard requirements*
15 *and a survey tool for health plans to use in order to comply with*
16 *subdivision (a).*
17 *(2) The regulations shall include standards and guidelines for*
18 *health care service plans to collect and report accurate and*
19 *complete member-level demographic data to more effectively assess*
20 *and report disparities in the number and prevalence of enrollees*
21 *and enrollees' reasons for going out of network and paying*
22 *out-of-pocket for behavioral health care services, and the total*
23 *expenditures paid out-of-pocket by enrollees, by utilizing survey*
24 *best practice methods compatible with identifying disparities for*
25 *smaller populations, including, but not limited to, all of the*
26 *following:*
27 *(A) Asian, Native Hawaiian and Pacific Islander, or American*
28 *Indian or Alaska Native populations.*
29 *(B) Lesbian, gay, bisexual, transgender, or queer+ populations.*
30 *(C) Persons with disabilities, including cognitive or functional*
31 *disabilities, or persons with accommodation needs.*
32 *(D) Other historically disadvantaged populations.*
33 *(3) The department shall consult with the Department of*
34 *Insurance regarding development of the regulations required by*
35 *this subdivision.*
36 *(4) The department shall additionally seek public input from a*
37 *wide range of interested parties through existing advisory bodies*
38 *established by the director.*

(5) The department shall finalize these regulations and standards by July 1, 2027, and plans shall be required to utilize these standards by October 1, 2027.

(c) The department shall develop an annual report based on data submitted pursuant to both of the following:

(1) The department's Annual Network Report submissions of network and nonnetwork behavioral health provider requests and determinations.

(2) The annual survey described in paragraph (1) of subdivision (a).

(d) For purposes of this section, the following definitions apply:

(1) "Culturally and linguistically competent care" means 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. At a minimum, "culturally and linguistically competent care" includes all of the following:

(A) Applying linguistic skills, including American Sign Language, to communicate effectively with the target population.

(B) Utilizing cultural information to establish therapeutic relationships.

(C) Eliciting and incorporating pertinent cultural data compatible with patient backgrounds, beliefs, and life experiences in diagnosis and treatment.

(D) Understanding and applying culturally, ethnically, and sociologically inclusive data to the process of clinical care, including, as appropriate, information and evidence-based cultural competency training pertinent to the treatment of, and provision of care to, individuals from racially and ethnically diverse cultural and linguistic backgrounds and who identify as lesbian, gay, bisexual, transgender, queer or questioning, asexual, intersex, or gender diverse. This subparagraph includes processes specific to those seeking gender-affirming care services.

(2) "Disparity" means variation in behavioral health care access, utilization, and costs between population groups by age, geographic area, primary language, race, ethnicity, sex, gender identity, sexual orientation, and disability status.

(3) "In-network" has the same meaning as "in-network coverage or services," as defined in Section 1374.60.

(4) "Member-level demographic data" means 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.

(5) "Out-of-network" or "out of network" has the same meaning as "out-of-network coverage or services," as defined in Section 1374.60.

(6) "Out-of-pocket" refers to copayments, coinsurance, and the applicable deductible, plus all costs for health care services that are not covered by the plan.

SEC. 5. Section 10127.22 is added to the Insurance Code, to read:

10127.22. (a) (1) A health insurer shall conduct an annual survey of all insureds in order to assess all of the following:

(A) Number and prevalence of insureds seeking or accessing behavioral health care services from out-of-network providers.

(B) Total expenditures paid out-of-pocket by insureds for out-of-network behavioral health care services and in-network behavioral health care services after copayments, coinsurance, and applicable deductibles are applied.

(C) The reasons for seeking or accessing out-of-network providers and paying out-of-pocket for behavioral health 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) The annual survey shall be optional for insureds to complete.

(3) To the extent practicable, a health insurer may incorporate questions to fulfill these requirements into insured surveys already conducted by the insurer.

(4) A health insurer shall report survey findings to the department on or before May 1, 2028, and annually thereafter.

(b) (1) In implementing this section, the department shall develop and adopt regulations establishing standard requirements and a survey tool for health plans to use in order to comply with subdivision (a).

(2) The regulations shall include standards and guidelines for health insurers to collect and report accurate and complete

member-level demographic data to more effectively assess and report disparities in the number and prevalence of insureds and insureds' reasons for going out of network and paying out-of-pocket for behavioral health care services, and the total expenditures paid out-of-pocket by insureds, by utilizing survey best practice methods compatible with identifying disparities for smaller populations, including, but not limited to, all of the following:

(A) Asian, Native Hawaiian and Pacific Islander, or American Indian or Alaska Native populations.

(B) Lesbian, gay, bisexual, transgender, or queer+ populations.

(C) Persons with disabilities, including cognitive or functional disabilities, or persons with accommodation needs.

(D) Other historically disadvantaged populations.

(3) The department shall consult with the Department of Managed Health Care regarding development of the regulations required by this subdivision.

(4) The department shall additionally seek public input from a wide range of interested parties through existing advisory bodies established by the commissioner.

(5) The department shall finalize these regulations and standards by July 1, 2027, and insurers shall be required to utilize these standards by October 1, 2027.

(c) The department shall develop an annual report based on data submitted pursuant to both of the following:

(1) Health insurer network adequacy reporting, including submissions of network and nonnetwork behavioral health provider requests and determinations.

(2) The annual survey described in paragraph (1) of subdivision (a).

(d) For purposes of this section, the following definitions apply:

(1) "Culturally and linguistically competent care" means 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. At a minimum, "culturally and linguistically competent care" includes all of the following:

1 *(A) Applying linguistic skills, including American Sign*
2 *Language, to communicate effectively with the target population.*
3 *(B) Utilizing cultural information to establish therapeutic*
4 *relationships.*
5 *(C) Eliciting and incorporating pertinent cultural data*
6 *compatible with patient backgrounds, beliefs, and life experiences*
7 *in diagnosis and treatment.*
8 *(D) Understanding and applying culturally, ethnically, and*
9 *sociologically inclusive data to the process of clinical care,*
10 *including, as appropriate, information and evidence-based cultural*
11 *competency training pertinent to the treatment of, and provision*
12 *of care to, individuals from racially and ethnically diverse cultural*
13 *and linguistic backgrounds and who identify as lesbian, gay,*
14 *bisexual, transgender, queer or questioning, asexual, intersex, or*
15 *gender diverse. This subparagraph includes processes specific to*
16 *those seeking gender-affirming care services.*
17 *(2) "Disparity" means variation in behavioral health care*
18 *access, utilization, and costs between population groups by age,*
19 *geographic area, primary language, race, ethnicity, sex, gender*
20 *identity, sexual orientation, and disability status.*
21 *(3) "In-network" means all of the following:*
22 *(A) All of the health care services provided or offered under the*
23 *requirements of this chapter that are received from a provider*
24 *employed by, under contract with, or otherwise affiliated with the*
25 *health insurer and in accordance with the procedures set forth in*
26 *the insurer's approved evidence of coverage.*
27 *(B) Health care services received from a provider not affiliated*
28 *with the health insurer when the plan arranges for the insured to*
29 *receive services from that provider.*
30 *(C) Out-of-area emergency care provided in accordance with*
31 *the procedures set by the health insurer to be followed in securing*
32 *these services.*
33 *(4) "Member-level demographic data" means information*
34 *specific to an individual insured that is self-reported by the insured*
35 *about their own race, ethnicity, language, sex, gender identity,*
36 *sexual orientation, disability status, and other characteristics.*
37 *(5) "Out-of-network" or "out of network" means health care*
38 *services received from either of the following:*
39 *(A) Providers who are not employed by, under contract with,*
40 *or otherwise affiliated with the health insurer, except for health*

1 *care services received from these providers in an emergency or*
2 *when referred or authorized by the plan under procedures*
3 *specifically reviewed and approved by the commissioner.*
4 *(B) Providers who are employed by, under contract with, or*
5 *otherwise affiliated with a health insurer in instances when the*
6 *"in-network coverage or services" requirements for care set forth*
7 *in the health insurer's approved evidence of coverage are not met.*
8 *(6) "Out-of-pocket" refers to copayments, coinsurance, and the*
9 *applicable deductible, plus all costs for health care services that*
10 *are not covered by the insurer.*
11 *SEC. 6. No reimbursement is required by this act pursuant to*
12 *Section 6 of Article XIII B of the California Constitution because*
13 *the only costs that may be incurred by a local agency or school*
14 *district will be incurred because this act creates a new crime or*
15 *infraction, eliminates a crime or infraction, or changes the penalty*
16 *for a crime or infraction, within the meaning of Section 17556 of*
17 *the Government Code, or changes the definition of a crime within*
18 *the meaning of Section 6 of Article XIII B of the California*
19 *Constitution.*

O