

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
STAFF 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. (LC §§ 192, 193)
- 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) **Staff Recommended Position.** Staff recommends that the Board consider taking 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 Conference of Machinists
- California Federation of Labor Unions, AFL-CIO
- California One care Education Fund
- California Pan - Ethnic Health Network
- California Psychological Association
- Courage California
- Healthy California Now
- National Association of Social Workers California Chapter
- Steinberg Institute
- The Kennedy Forum
- Unite Here International Union, AFL-CIO

Opposition:

- Association of California Life & Health Insurance Companies
- California Association of Health Plans
- California Medical Association
- Kaiser Permanente

5) **History.**

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>

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**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:

- 1 SECTION 1. This act shall be known and may be cited as the
- 2 Behavioral Health Provider Comparable Worth Study Act.
- 3 SEC. 2. The Legislature finds and declares all of the following:
- 4 (a) California faces a behavioral health crisis that threatens the
- 5 well-being, safety, and economic security of millions of its
- 6 residents.
- 7 (b) This crisis is in significant measure the result of the difficulty
- 8 many Californians face in accessing behavioral health services.
- 9 (c) Access problems are driven in part by systemic
- 10 undervaluation of behavioral health care by health insurers,
- 11 resulting in direct compensation to behavioral health providers
- 12 and reimbursement to intermediaries that are insufficient to

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

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

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

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

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

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

24

25 **Chapter 9. Behavioral Health Provider Comparable**
26 **Worth Study**

27

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

30 (a) "Behavioral health provider" means a psychiatrist,
31 psychologist, licensed clinical social worker, licensed marriage
32 and family therapist, licensed professional clinical counselor,
33 psychiatric mental health nurse practitioner, or other licensed or
34 certified professional who provides mental health or substance use
35 disorder treatment services.

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

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

- 1 (d) “Health care service plan” has the same meaning as defined
- 2 in Section 1345 of the Health and Safety Code.
- 3 (e) “Health insurer” means an insurer licensed to provide health
- 4 insurance in this state pursuant to the Insurance Code.
- 5 (f) “Health system” means a hospital, hospital system, integrated
- 6 delivery system, or other organization that both receives payments
- 7 from health care service plans or health insurers for health care
- 8 services and employs or contracts with health care providers to
- 9 deliver those services.
- 10 (g) “Intermediary” means a platform, independent practice
- 11 association, medical group, managed behavioral health care
- 12 organization, or other entity that contracts with health care service
- 13 plans or health insurers to arrange for or provide access to health
- 14 care services and that, in turn, employs or contracts with health
- 15 care providers to deliver those services. “Intermediary” does not
- 16 include a health system.
- 17 (h) “Managed behavioral health care organization” means an
- 18 entity, such as a specialized health plan, mental health plan, or
- 19 delegate, to which a health care service plan or health insurer has
- 20 delegated responsibility for arranging, managing, or administering
- 21 mental health or substance use disorder services.”
- 22 (i) “Medical-surgical provider” means a physician, physician
- 23 assistant, nurse practitioner, registered nurse, or other licensed or
- 24 certified health care professional who provides medical or surgical
- 25 treatment services, excluding behavioral health services.
- 26 (j) “Platform” means a digital health company or other
- 27 technology-enabled entity that contracts with health care service
- 28 plans, managed behavioral health care organizations, health
- 29 insurers, or health systems to provide access to health care
- 30 providers.
- 31 (k) “Reimbursement” means payment made by a health care
- 32 service plan or health insurer for health care services, whether paid
- 33 directly to a provider, to a health system, or to an intermediary.
- 34 191. (a) The department, in consultation with the Department
- 35 of Managed Health Care, the Department of Insurance, the
- 36 Department of Health Care Access and Information, and the Office
- 37 of Health Care Affordability, shall conduct a comparable worth
- 38 study to examine and compare compensation and reimbursement
- 39 for behavioral health providers with compensation and
- 40 reimbursement for similarly situated medical-surgical providers.

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

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

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

9 (3) Payments made by intermediaries and health systems to
10 behavioral health providers and medical-surgical providers, whether
11 as employee compensation or as payments to independent
12 contractors.

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

15 (1) Develop a methodology for determining which behavioral
16 health provider roles are comparable to which medical-surgical
17 provider roles, considering factors including, but not limited to,
18 all of the following:

19 (A) Required skills and expertise.

20 (B) Education requirements.

21 (C) Specialized training.

22 (D) Licensure and certification requirements.

23 (E) Similarity of working conditions.

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

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

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

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

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

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

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

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

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

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

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

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

19 (3) The contractual structure of each arrangement, including
20 whether payments are made on a capitated, fee-for-service, or other
21 basis, and any risk-sharing or performance-based payment terms.

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

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

30 (1) The identity of each health care service plan and health
31 insurer from which the intermediary or health system receives
32 payment for behavioral health services or medical-surgical services.

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

36 (3) The contractual structure of each arrangement, including
37 whether payments are received on a capitated, fee-for-service, or
38 other basis, and any risk-sharing or performance-based payment
39 terms.

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

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

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

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

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

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

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

24 (b) The department, the Department of Managed Health Care,
25 the Department of Insurance, the Department of Health Care
26 Access and Information, and the Office of Health Care
27 Affordability shall protect the confidentiality of any proprietary
28 or commercially sensitive information submitted pursuant to this
29 chapter and shall publish only aggregated data that does not reveal
30 information about individual entities or individual providers.

31 195. An entity that fails to comply with the reporting
32 requirements established pursuant to this chapter shall be subject
33 to a civil penalty of up to ten thousand dollars (\$10,000) per day
34 for each day of noncompliance, to be assessed and collected by
35 the department.

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

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

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

4 (2) The medical-surgical provider roles identified for inclusion
5 in the study pursuant to paragraph (2) of subdivision (c) of Section
6 191.

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

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

13 (5) An analysis of how compensation and reimbursement levels
14 change as payments pass through intermediaries and health
15 systems, including any differential treatment of behavioral health
16 services as compared to medical-surgical services.

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

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

28 198. The department may adopt regulations to implement this
29 chapter. Any regulations adopted pursuant to this section shall be
30 adopted as emergency regulations in accordance with Chapter 3.5
31 (commencing with Section 11340) of Part 1 of Division 3 of Title
32 2 of the Government Code. The adoption of emergency regulations
33 pursuant to this section shall be deemed an emergency and
34 necessary for the immediate preservation of the public peace,
35 health, safety, or general welfare.

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

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

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

O