SENATE JUDICIARY COMMITTEE
Senator Thomas Umberg, Chair
2025-2026 Regular Session

SB 747 (Wiener)
Version: March 24, 2025
Hearing Date: April 29, 2025
Fiscal: Yes
Urgency: No
ID

SUBJECT

Wages: behavioral health and medical-surgical employees

DIGEST

This bill requires specified covered employers to report to the Department of Industrial Relations the compensation it provides to behavioral health employees and to medical-surgical employees, and provides for enforcement of this requirement by the Department of Industrial Relations through a court order and civil penalties, as specified.

EXECUTIVE SUMMARY

Mental health and substance abuse is a serious issue in California and throughout the United States. However, access to behavioral health care services for far too many Californians has long been very limited, creating what many have called a mental health crisis in America. Recognizing this, Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Pub. L. No. 110-343, 122 Stats. 3765) (MHPAEA). The MHPAEA aimed to create parity between mental health or substance use disorder benefits and medical or surgical benefits. This requirement of parity requires health care providers to document and evaluate their policies and non-quantitative treatment limitations. These treatment limitations could include efforts to recruit and keep behavioral health providers, including through compensation. SB 747 requires certain health care providers to provide a report to the Department of Industrial Relations with the compensation that they provide mental health and substance use disorder employees and medical-surgical care employees, and provides the Department of Industrial Relations with the ability to enforce the requirement through a court order and civil penalties, as specified. SB 747 is sponsored by the National Union of Health Workers, and is supported by a variety of healthcare and worker organizations. It is opposed by the California Chamber of Commerce, Kaiser Permanente, and a number of health care groups. SB 747 previously passed out of the Senate Labor, Public Employment and Retirement Committee by a vote of 4 to 0.

PROPOSED CHANGES TO THE LAW

Existing federal law:

1) Establishes the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) to prevent group health plans and health insurance issuers that provide mental health or substance use disorder benefits from imposing more limitations on those benefits than on medical-surgical benefits, and to provide guidance for such plans to comply with this requirement. (42 U.S.C. 300gg-26.)

Existing state law:

1) Establishes the Department of Industrial Relations (DIR) within the Labor and Workforce Development Agency for the purposes of fostering, promoting, and the development the welfare of workers in California, and improving working conditions. (Lab. Code §§ 50 et seq.)

2) Requires every employer to maintain records of the wages, rates, job classifications, and other conditions of employment of the persons employed by the employer, and requires employers to keep such records for a period of three years. (Lab. Code § 1197.5(e).)

3) Requires an employer to maintain records of a job title and wage rate history for each employee for the duration of that employee's employment, and for another three years, in order for the Labor Commissioner to determine if there is still a pattern of wage discrepancy, as provided. Specifies that the records must be open to inspection by the Labor Commissioner. (Lab. Code § 432.3(c)(4).)

4) Requires that, no later than January 1, 2015, a large group health care service plan contract provide all covered mental health and substance use disorder benefits in compliance with the MHPAEA, as well as the rules, regulations, and guidance issued pursuant to that act. (Heath & Saf. Code § 1374.76(a).)

5) Establishes the Knox-Keene Health Care Service Plan Act of 1975 to regulate and license health care service providers, providing for various standards for the provision of health care services by those plans in the state. (Health & Saf. Code § 1340.)

This bill:

1) Requires a covered employer to report to the DIR the compensation that it provides to behavioral health employees and to medical-surgical employees.

2) Specifies that, if DIR does not receive the report as required by (1), above, DIR may seek a court order requiring the employer to comply, and entitles DIR to recover the costs associated with seeking the order.

3) Permits the court, upon request by DIR, to impose a civil penalty not to exceed $100 per employee upon any employer in violation of (1), above, and not to exceed $200 per employee for any subsequent violation.

4) Specifies that a violation of its provisions does not constitute a misdemeanor under specified law.

5) Provides the following definitions for its provisions:
    a) "Behavioral health employee" to mean an employee engaged in a profession regulated by the Board of Psychology or the Board of Behavioral Sciences, a psychiatric or mental health nurse regulated by the Board of Registered Nursing, a counselor for alcohol or drug dependency with a certification approved by the Department of Health Care Services, or a qualified autism service provider.
        i. Specifies that "behavioral health employee" includes a contracted or subcontracted individual who provides behavioral health care services or services supporting the provision of behavioral health care as a contractor to the covered employer, or who provides the covered employer with behavioral health care services or services supporting the provision of behavioral health care as an employee of, or contractor to, an entity that contracts with the employer.
    b) "Covered employer" to mean either: a medical group exclusively contracted by a nonprofit health care service plan with at least 3,500,000 enrollees that owns or operates its own pharmacies to provide medical services to its enrollees within a specified geographic region; or a health care service plan with at least 3,500,000 enrollees that owns or operates its own pharmacies and that provides health care services to enrollees in a specific geographic area through a mutually exclusive contract with a single medical group.
    c) "Medical-surgical employee" to mean an employee engaged in a profession regulated by the Physician Assistant Board, the California Board of Occupational Therapy, the Physical Therapy Board of California, the California Board of Recreation Therapy Certification, the California Board of Occupational Therapy, the Respiratory Care Board of California, the Radiologic Health Branch within the Department of Public Health, or the Speech-Language Pathology and Audiology and Hearing Air Dispenser Board, or an employee engaged in a profession regulated by the Board of Registered Nursing that provides medical-surgical care.

COMMENTS

1. Author's statement

According to the author:

> The mental health crisis in California has reached alarming levels, affecting millions of people across all age groups and backgrounds. Rising rates of anxiety, depression, and other mental illnesses have been exacerbated by social and economic pressures, lack of access to care, and lingering stigma surrounding mental health issues. Despite growing awareness, many individuals still struggle to receive proper treatment due to the shortage of mental health professionals. The disparities in compensation between similarly situated behavioral health providers and medical-surgical providers contributes to shortages of behavioral health professionals, which makes it difficult to meet the growing demand for mental health and substance use disorder treatments. SB 747 recognizes that mental health parity remains an unfulfilled promise in California's healthcare system, and urges healthcare service plans to report their compensation data to promote transparency that can help illuminate the extent of wage disparities. SB 747 will produce data that can be used in future policy interventions that can provide a remedy that can address these disparities.

2. Mental health parity is essential for Californians' health

Mental health and substance abuse is a serious issue in California and throughout the United States. An estimated 47.6 million adults in the United States, or 19.1% of the adult population, had a mental illness in 2018.[1] In addition, 20.3 million people over the age of 12 had a substance use disorder related to alcohol or drugs in the past year.[2] Yet the numbers have only gotten worse, as the COVID-19 pandemic greatly increased rates of anxiety, depression, and suicidality, and exacerbated mental health issues for many who were managing mental health issues before the pandemic.[3] This has led many to claim that the United States is in a "mental health crisis," in which rates of mental health illnesses and substance use disorders are greatly increasing, while access to care to treat such illnesses remains limited.

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[1] Abuse and Mental Health Services Administration, Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health, U.S. Dept. of Health & Hum. Svcs. (Aug. 2019), available at https://library.samhsa.gov/product/results-2018-national-survey-drug-use-and-health-nsduh-key-substance-use-and-mental-health.

[2] *Id.*

[3] Thomas Insel, America's Mental Health Crisis, Pew Charitable Trusts (Dec. 8, 2023), https://www.pewtrusts.org/en/trend/archive/fall-2023/americas-mental-health-crisis#:~:text=A%20report%20in%20JAMA%20Health,lethal%20drugs%20such%20as%20fentanyl.

3. The Mental Health Parity and Addition Equity Act helps ensure parity

Despite the prevalence of mental health illnesses and substance use disorders, insurance coverage for and the availability of mental health care historically has been limited. Recognizing this, efforts dating back to the 1960s have attempted to increase the availability of such care. One of the earliest calls came from President John F. Kennedy, who called on the U.S. Civil Services Commission to require the health insurer of federal employees to cover psychiatric illness care at a level equivalent to general medical care.[4] Yet federal laws to create parity in coverage of and access to mental health care with other types of medical care did not come into being until the nineties. In 1996, the United States Congress passed the Mental Health Parity Act of 1996 (MHPA), which required group health plans with 50 or more employees that offered mental health benefits to provide equivalent annual and lifetime limits for mental health benefits to what they did for medical or surgical benefits. (Pub. L. No. 104-204, 110 Stat. 2944.) However, the MHPA did not cover substance use disorder treatments, and did not address broader coverage parity. It also exempted employers with between two to fifty employees.

In 2008, the MHPA was supplanted and expanded upon by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Pub. L. No. 110-343, 122 Stats. 3765) (MHPAEA). MHPAEA aimed to prevent group health plans and health insurance issuers that provide mental health or substance use disorder benefits from imposing less favorable benefit limitations on those benefits than on other medical or surgical benefits. It expanded the parity requirements of the MHPA to include parity in treatment limitations (such as on the frequency of treatment or days of coverage), financial requirements (such as deductibles and copayments), and in- and out-of-network benefits. However, the MHPAEA did not apply to the individual health insurance marketplace. In 2010, the Affordable Care Act expanded its reach to include parity requirements in qualified health plans, certain Medicaid plans, and plans offered through the individual market. (Pub. L. No. 111-148, 124 Stat. 119.)

The MHPAEA was further amended by the Consolidated Appropriations Act of 2021 (Pub. L. No. 116-260, 134 Stat. 1182) to prohibit covered health plans that impose non-quantitative treatment limitations (NQTLs) from also imposing NQTLs for mental health and substance use disorder benefits that are more restrictive than those for medical or surgical benefits. It also required covered plans to complete and document a comparative analysis of NQTLs between mental health and substance use disorder benefits and medical and surgical benefits to ensure compliance. NQTLs are non-financial restrictions that health care plans use to limit benefits, such as requirements for prior authorization. The Consolidated Appropriations Act required the implementing Departments to issue guidance providing clarifying information and

[4] Colleen L. Barry et al., A Political History of Federal Mental Health and Addition Insurance Parity, Milbank Q. Vol. 88, Issue 4, p. 404 (Sept. 2010), https://pmc.ncbi.nlm.nih.gov/articles/PMC2950754/.

illustrative examples of the methods, processes, strategies, evidentiary standards, and other factors that group health plans may use to develop and apply NQTLs to ensure parity, and guidance regarding the data that plans must provide.(26 U.S.C. § 9812(a)(8).)

The regulations to implement the MHPAEA were originally published in 2013. However, new final rules implementing the MHPAEA were published on September 9, 2024. The new regulations included standards related to network compensation as an illustrative example of a NQTL that must have parity. Network compensation standards include: standards for provider and facility admission to participate in a network; methods for reimbursement rates; credentialing standards; and procedures for ensuring the network includes an adequate number of each category of provider or facility. (45 CFR § 146.136(c)(4)((ii)(D).) If the data that a provider must collect demonstrates that differences in NQTLs between mental health and substance use disorder benefits and medical or surgical benefits create a material difference in access to care, the provider must take reasonable action to address those material differences. This include: strengthening efforts to recruit and encourage a broad range of mental health and substance use disorder providers and facilities for the plan's network; streamlining the credentialing process; and increasing compensation for mental health and substance use disorder providers. (45 CFR § 146.136()(C)(1).)

California's own laws regarding health care plans also include language requiring regulated plans to comply with the MHPAEA and its implementing regulations. The Knox-Keene Health Care Service Plan Act of 1975 (AB 138, Ch. 941, Stats. 1975) provides for the licensure and regulation of health care service plans in California by the Department of Managed Health Care (DMHC), and establishes certain standards for health care services. Those standards include requirements for prompt follow-up care and appointment availability, quality assurance monitoring, and more. It also requires that covered plans be in compliance with the MHPAEA. (Health & Saf. Code §§ 1367.005(a)(2)(D), 1374.76(a).)

4. <u>SB 747 proposes to require certain healthcare employers to provide compensation data to DIR</u>

SB 747 proposes to require a certain medical groups to provide information regarding the compensation they provide to their behavioral health employees and medical-surgical employees. It would require that a covered provider report the compensation it provides to those two categories of employees to DIR. Additionally, it specifies that, if DIR does not receive this report from a covered employer, DIR may seek an order requiring the employer to comply. In seeking such an order, SB 747 permits DIR to recover the costs associated with that action. SB 747 also permits a court to impose a civil penalty of $100 per employee upon any employer who fails to provide the required compensation, and a penalty of $200 per employee for any subsequent violation.

SB 747's requirements only apply to certain medical providers. By its provisions, it only applies to: a medical group exclusively contracted by a nonprofit health care service plan with at least 3,500,000 enrollees that owns or operates its own pharmacies to provide medical services within a specified geographic region; and to a health care service plan with at least 3,500,000 enrollees that owns or operates its own pharmacies that provides health care services in a specific geographic area through a mutually exclusive contract with a single medical group.

5. The proponents' and opponents' arguments

The author and the sponsor of the bill, the National Union of Health Workers (NUHW), asserts that SB 747 is necessary to address parity for mental health and substance use disorder care with medical-surgical care. They assert that SB 747 is a transparency tool that will help the state evaluate the degree to which there is a disparity between the compensation of behavioral health care providers and medical-surgical care providers, which is an important factor in the access to quality behavioral health care. They assert that the disparity leads to an undervaluation of behavioral health services that creates persistent shortages in behavioral health professionals, high turnover rates, and growing difficulty meeting the increasing demand for behavioral health services. Furthermore, the sponsor asserts that health care service plans claim that they are compliant with MHPAEA's parity requirements for behavioral health services and medical-surgical services because they have parity of compensation between behavioral health providers and medical-surgical services providers, but that the veracity of this assertion is not possible to ascertain without access to compensation data.

Kaiser Permanente, which is opposed to the bill, argues that the extremely specific definition of covered employer means that SB 747 would essentially only apply to it. Indeed, Kaiser Permanente reports 4.6 million members for its Northern California region, and 4.8 million members for its Southern California region, thus meeting the enrollee requirement.[5] Kaiser Permanente also argues that this data reporting would divert its resources and attention away from patient care and service delivery. It asserts that there is no public policy purpose for this reporting.

The NUHW and Kaiser Permanente have been in a protracted labor dispute in the last few years. Earlier this year, NUHW members in Southern California went on strike, as the contract negotiations continued.[6] At the heart of the union and Kaiser Permanente's dispute are claims of overly long patient wait times and heavy clinician workloads for

[5] Kaiser Permanente, "Fast Facts: Our Company" (Dec. 31, 2024), https://about.kaiserpermanente.org/who-we-are/fast-facts.
[6] National Union of Health Workers, "Kaiser mental health professionals launch L.A. hunger strike," (Apr. 4, 2025), https://home.nuhw.org/2025/04/04/kaiser-mental-health-professionals-launch-l-a-hunger-strike/; Kaiser Permanente, "NUHW bargaining updates," https://about.kaiserpermanente.org/who-we-are/labor-relations/nuhw-bargaining/nuhw-bargaining-updates.

behavioral health services. DMHC just earlier this month released a report that found that Kaiser Permanente has failed in the last few years to meet and address deficiencies regarding various standards required by the Knox-Keene Act for its mental health and substance use disorder care, including relating to the timelines for patient appointments.[7] In 2019, Kaiser Permanente was ordered to pay $200 million by the DMHC for deficiencies in its behavioral health services.[8] Kaiser Permanente asserts that it provides behavioral health services above the state's standards, and that it has been investing in and expanding its mental health care workforce and provider network.

6. Amendments

Amendments were taken on SB 747 when the bill was before the Senate Labor, Public Employment and Retirement Committee. However, due to the brief amount of time between that hearing and this Committee's hearing on SB 747, those amendments will be taken in this Committee. Those amendments require that any data regarding compensation that is reported is to be confidential, and that DIR produce a report of non-specific, aggregated data to be provided to the Legislature. A mock-up of these amendments is attached at the end of this analysis.

The California Constitution and laws generally recognize that public access to information regarding the conduct of the people's business is a fundamental right. However, this right must be balanced against the right to privacy. Thus, the general right of access to public records may be limited where the Legislature finds a public policy justification necessitating limiting access. These amendments to SB 747 limit access to public records by requiring that DIR keep the compensation data submitted by a covered employer confidential. The purpose of this limitation is to protect the privacy of this sensitive data and to avert interference in healthcare market pricing mechanisms. Considering the potential that such data could interfere with the healthcare market pricing by allowing a covered employer's competitor access to this sensitive data, as thoroughly described in the Senate Labor Committee analysis, this limitation on the public's access to this information seems warranted.

[7] Office of Plan Monitoring, Final Report: Nonroutine Survey of Kaiser Foundation Health Plan, Inc., Dept. of Managed Health Care (Feb. 25, 2025), https://www.dmhc.ca.gov/LicensingReporting/HealthPlanComplianceMedicalSurvey/ViewMedicalSurveyReports/hmoPlan/055.aspx.

[8] Ana B. Ibarra, "Kaiser Agrees to $200 million settlement over California mental health delays, CalMatters (Oct. 12, 2023), https://calmatters.org/health/2023/10/kaiser-permanente-california-behavioral-health-settlement/.

7. Arguments in support

According to the National Union of Health Workers, which is the sponsor of SB 747:

> The bill addresses a critical gap in our state's efforts to ensure true behavioral health parity in our healthcare system. Despite existing federal and state mental health parity laws and regulations, significant disparities in compensation between behavioral health providers and medical-surgical providers persist, contributing to severe shortages of qualified behavioral health professionals, high turnover rates, and widespread difficulty in meeting the growing demand for behavioral health and substance use disorder treatment.
>
> […]
> Californians face growing challenges in accessing care from qualified behavioral health providers, including psychologists, psychiatric nurses, marriage and family therapists, clinical social workers, substance use counselors, and qualified autism service providers. Millions of Californians are forced to wait months to see qualified behavioral health providers as a result, putting their lives and safety at risk. Comprehensive research, including a recent study by RTI International, establishes that significant compensation disparities exist between similarly situated behavioral health providers and medical-surgical providers. Their report, "Behavioral Health Parity–Pervasive Disparities in Access to In-Network Care," documents how these disparities contribute to the behavioral health workforce crisis we face today.
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> The disparities are not merely an issue of compensation fairness but have profound implications for patient access to care. When behavioral health professionals are systematically undervalued and underpaid compared to their medical-surgical counterparts, we see:
> 1. Persistent shortages of qualified behavioral health professionals who can provide timely care
> 2. High turnover rates among behavioral health staff, disrupting continuity of care
> 3. Growing difficulty meeting the increasing demand for behavioral health and substance use disorder treatment services
>
> The United States Department of Labor's regulations implementing the federal Mental Health Parity and Addiction Equity Act (MHPAEA) prohibit health care service plans from applying factors, processes, and strategies to set provider compensation for behavioral health services that are not comparable to, or are more stringent than, those used to set provider compensation for medical-surgical services.

Health care service plans may assert, and some have asserted, in their MHPAEA compliance filings that parity of compensation between similarly situated providers of behavioral health services and medical-surgical services should be taken as evidence of their compliance with the law's requirements. However, without ready access to necessary data, the State of California has no reliable way to determine whether health care service plans that assert this basis for compliance do in fact demonstrate true parity of compensation. […] SB 747 would address this critical gap by requiring large integrated healthcare systems to report their compensation data to the Department of Industrial Relations. […]

Importantly, SB 747 is narrowly tailored to focus only on large integrated healthcare systems and medical groups with significant numbers of both behavioral health and medical-surgical workers. This approach ensures we capture data from entities where health care service plans and medical groups coordinate in setting compensation, while not imposing unnecessary burdens on smaller providers. […]

In the same way that wage transparency has proven effective in addressing gender and racial pay gaps in other sectors, compensation data transparency in healthcare can help address the systematic undervaluation of behavioral health services. This undervaluation of behavioral health services creates barriers to timely access to appropriate care, and these access barriers contribute to and exacerbate our state’s behavioral health crisis. […]

SB 747 would also strengthen California's ability to assess health plans' compliance with federal parity requirements. The MHPAEA requires that the processes, strategies, evidentiary standards, and other factors used to determine compensation and reimbursement rates for behavioral health services be comparable to and applied no more stringently than those used for medical-surgical services.

Health plans often assert that their compensation practices comply with this requirement, but without access to actual compensation data, regulators cannot verify these claims. By requiring reporting of compensation data, SB 747 would provide a foundation for meaningful assessment of parity compliance.

The lack of access to affordable, timely behavioral health services in California is reaching crisis levels, with Californians in rural communities facing a severe shortage of providers. According to the California Health Care Foundation, 52% of Californians who sought behavioral health care reported difficulty finding a provider who would accept their insurance, and 55% reported unreasonable wait times for behavioral health treatment.

> By creating transparency around compensation disparities that contribute to these workforce and access shortages, SB 747 represents an important step toward developing effective solutions to ensure all Californians can access the behavioral health care they need.

8. Arguments in opposition

According to Kaiser Permanente, which opposes SB 747:

> SB 747 will divert resources and attention away from core patient care and service delivery by mandating that "covered employers" report detailed wage data for behavioral health and medical-surgical employees, including those who are contracted or subcontracted to do this work. Requiring detailed compensation reporting presents privacy and data security concerns when compiling and reporting sensitive wage and employee data, creating additional vulnerabilities for the misuse of private wage information.
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> While the sponsors of the bill imply that this bill would apply to any large health care service plan, the reality is that the bill's narrow definition of a "covered employer" is designed to target one organization, and one organization only -- Kaiser Permanente. The bill would create a precedent of legislative intervention in collective bargaining negotiations. For this reason, the bill would be preempted by federal labor law and unenforceable.
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> SB 747 requires the disclosure of sensitive personal salary and wage information to a state agency with no clear public policy purpose for doing so – especially considering the data that will be sent to the state under this bill would come from only one health care employer, giving the state skewed, incomplete, and distorted data from one employer that generally pays their workforce above market rates.
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> Despite claims from the sponsors, Kaiser Permanente's network of 20,000 employed and contracted mental health care providers are delivering care to ensure that patients can receive non-urgent appointments on average within 6 days, which exceeds the state's requirement. Members with urgent needs can get appointments within 48 hours, and we have staff available for anyone in crisis to get care 24 hours a day, 7 days a week.

SUPPORT

National Union for Health Workers (NUHW) (sponsor)
California Alliance for Retired Americans
California Federation of Labor Unions, AFL-CIO
California Onecare

Courage California
Health Care for All - California
Healthy California Now
Nasw California
Unite Here International Union, AFL-CIO

OPPOSITION

America's Physician Groups
Av Edge (antelope Valley Economic Development & Growth Enterprise)
Cal Asian Chamber of Commerce
California African American Chamber of Commerce
California Asian Pacific Chamber of Commerce
California Association of Health Plans
California Chamber of Commerce
California Hispanic Chambers of Commerce
California Hospital Association
California Medical Association
Chino Valley Chamber of Commerce
Garden Grove Chamber of Commerce
Kaiser Permanente
Oakland Chamber of Commerce
Orange County Business Council
Sacramento Hispanic Chamber of Commerce
Sacramento Metro Chamber of Commerce
San Francisco Chamber of Commerce
West Ventura County Business Alliance

RELATED LEGISLATION

Pending Legislation:

AB 1429 (Bains, 2025) requires the Kaiser Foundation Health Plan to fully reimburse an enrollee who incurs out-of-pocket costs for behavioral health care services obtained from non-Kaiser providers or facilities or non-Kaiser pharmacies on or after May 1, 2022, until DMHC certifies to the Legislature that Kaiser has successfully completed implementation of a corrective action work plan resulting from its settlement agreement with DMHC. AB 1429 is currently pending before the Assembly Health Committee.

AB 1032 (Harabedian, 2025) requires an individual or group health care service plan contract or health insurance policy issued, amended, or renewed after January 1, 2026 to reimburse an eligible enrollee for up to 12 visits per year with a licensed behavioral health provider, if the enrollee is in a county where a local or state emergency has been

declared due to wildfires. AB 1032 is currently pending before the Assembly Health Committee.

Prior Legislation:

SB 964 (Wiener, 2022) required DMHC to commission consultants to prepare a report to the Legislature that provides an analysis of the current behavioral health workforce and the state's behavioral health workforce needs, and recommendations on how to address the state's behavioral health workforce shortage. SB 964 was vetoed by the Governor because of cost concerns.

PRIOR VOTES:

Senate Labor, Public Employment and Retirement Committee (Ayes 4, Noes 0)

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Mock-up of Amendments to 2025-2026 SB 747 (Wiener)

(Amendments may be subject to technical changes by Legislative Counsel)

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1197.6 is added to the Labor Code, to read:

1197.6. (a) A covered employer shall report to the Department of Industrial Relations the compensation it provides to behavioral health employees and to medical-surgical employees.

(b) (1) If the department does not receive a report from a covered employer as required by this section, the department may seek an order requiring the employer to comply with this section and shall be entitled to recover the costs associated with seeking the order.

(2) Upon request by the department, a court may impose a civil penalty not to exceed one hundred dollars ($100) per employee upon any employer in violation of this section and not to exceed two hundred dollars ($200) per employee upon any employer for any subsequent violations of this section.

(c) Except as provided in subdivision (d), any data regarding the compensation of behavioral health employees and medical-surgical employees reported by a covered employer pursuant to this section shall be exclusively available to the department, the Department of Health Care Access and Information, and the Department of Managed Health Care, and shall be confidential and not made publicly available.

(d) (1) The department shall consult with the Department of Health Care Access and Information and the Department of Managed Health Care regarding the data, and thereafter, the department shall produce non-specific aggregated data, analyze any data regarding the compensation of behavioral health employees and medical-surgical employees received pursuant to this section and incorporate that data into a report that identifies any compensation disparities between behavioral health employees and similarly-situated medical-surgical employees.

(2) (A) The department shall, on or before January 1, 2027, submit the report described in paragraph (1) to the Legislature.
(B) (i) The requirement for submitting a report imposed under this paragraph is inoperative on January 1, 2031, pursuant to Section 10231.5 of the Government Code.
(ii) A report to be submitted pursuant to this paragraph shall be submitted in compliance with Section 9795 of the Government Code.

~~(c)~~ **(e)** A violation of this section shall not constitute a misdemeanor under Section 1199.

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

(1) (A) "Behavioral health employee" means an employee engaged in a profession regulated by the Board of Psychology or the Board of Behavioral Sciences, a psychiatric or mental health nurse regulated by the Board of Registered Nursing, a counselor for alcohol or drug dependency with a certification approved by the State Department of Health Care Services, or a qualified autism service provider.

(B) "Behavioral health employee" includes a contracted or subcontracted individual under either of the following circumstances:

(i) The individual provides behavioral health care services or services supporting the provision of behavioral health care as a contractor to the covered employer.

(ii) The individual provides the covered employer with behavioral health care services or services supporting the provision of behavioral health care as an employee of, or as a contractor to, an entity that contracts with the covered employer.

(2) "Covered employer" means either of the following:

(A) A medical group exclusively contracted by a nonprofit health care service plan with at least 3,500,000 enrollees that owns or operates its own pharmacies to provide medical services to its enrollees within a specified geographic region.

(B) A health care service plan with at least 3,500,000 enrollees that owns or operates its own pharmacies and that provides health care services to enrollees in a specific geographic area through a mutually exclusive contract with a single medical group.

(3) "Medical-surgical employee" means an employee engaged in a profession regulated by the Physician Assistant Board, the California Board of Occupational Therapy, the Physical Therapy Board of California, the California Board of Recreation Therapy Certification, the California Board of Occupational Therapy, the Respiratory Care Board of California, the Radiologic Health Branch within the State Department of Public Health, or the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board, or an employee engaged in a profession regulated by the Board of Registered Nursing that provides medical-surgical care.

SEC. 2. The Legislature finds and declares that Section 1 of this act, which adds Section 1197.6 to 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:

1. ***The data to be reported to the department is necessary to understand and address pay disparity between behavioral health employees and medical/ surgical employees and to promote increased Californians access to behavioral healthcare.***
2. ***The limitation is necessary to avert unintended interference in healthcare market pricing mechanisms.***