Date of Hearing: March 17, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 1629 (Haney) – As Introduced January 26, 2026

SUBJECT: Dental coverage.

SUMMARY: Requires a health care service plan (health plan) or health insurer, if they pay a contracting dental provider directly for covered services, to pay a non-contracting dental provider directly for covered services if the non-contracting provider submits a written assignment of benefits (AOB) form signed by the enrollee. Specifically, **this bill**:

1) Requires a non-contracting dental provider, before accepting an AOB, to disclose the following information to an enrollee:

   a) That the provider is a non-contracting dental provider;

   b) That the enrollee may experience lower out-of-pocket costs if services are rendered by a contracting network dentist; and,

   c) An estimate of what the planned treatment would cost and the enrollee's portion of the cost.

2) Requires a health plan or health insurer to provide notice to an enrollee that the out-of-network cost may count towards their annual or lifetime maximum, as applicable and that payment was sent to the provider.

3) Requires a dental plan or insurer to provide a predetermination or prior authorization to the dental provider. Prohibits the dental plan or insurer from reimbursing the provider less than the amount set forth in the predetermination or prior authorization for the services, except in cases of fraud, billing error, or loss of coverage.

4) Requires information reported by a dental plan or insurer to the Department of Managed Health Care (DMHC) or California Department of Insurance (CDI) to include comprehensive information regarding the dental provider networks that each dental provider serves. Specifies comprehensive information includes the number of covered lives per line of business, including self-insured, third party, or administrative service organizations, as applicable. For the purpose of determining network adequacy and compliance with time and distance requirements, requires the departments to review the adequacy of an entire dental provider network, as reported by the health care service plans, including the portions of the network serving plans and insurers not regulated by the department.

EXISTING LAW:

1) Establishes DMHC to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 and CDI to regulate health insurance. [Health and Safety Code (HSC) § 1340, *et seq*. and Insurance Code (INS) § 106, *et seq*.]

2) Requires DMHC to develop and adopt regulations to ensure that enrollees have access to health care services in a timely manner, regarding:

   a) Waiting times for appointments, including primary and specialty care physicians;

   b) Care in an episode of illness, including timeliness of referrals and obtaining other services, as needed; and,

   c) Waiting time to speak to a physician, registered nurse, or other qualified health professional trained to screen or triage. [HSC § 1367.03]

3) Requires, in developing these standards, DMHC to consider the clinical appropriateness, the nature of the specialty, the urgency or care, and the requirements of law governing utilization review. Permits DMHC to develop reporting methodologies. [HSC § 1367.03]

4) Requires CDI to promulgate regulations applicable to health insurers to ensure access to health care in a timely manner, and designed to ensure adequacy of the number of locations of institutional facilities and professional providers, adequacy of number of professional providers, and license classifications, consistent with standards of good health care and clinically appropriate care, and that contracts are fair and reasonable. [INS § 10133.5]

5) Requires, in designing the regulations, CDI to consider regulations promulgated by DMHC and all other relevant guidelines in an effort to accomplish maximum accessibility within a cost-efficient system of indemnification. Requires insurers to report annually on complaints and for CDI to review complaints and make reported information public. [INS § 10133.5]

6) Requires, for a plan or insurer offering coverage for dental services, urgent dental appointments to be offered within 72 hours of a request, non-urgent dental appointments to be offered within 36 business days of a request, and preventive dental care appointments to be offered within 40 business days of a request. [HSC § 1367.03 and INS § 10133.54]

FISCAL EFFECT: Unknown. This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, every month, millions of Californians pay their monthly dental insurance bill but never get the care they are entitled to. Dental insurance providers intentionally make it difficult to use their insurance by delaying, denying, or barely covering the cost of care. The author states that California has over 35,000 active dentists which is the most in the nation. The author argues that the issue isn't a lack of dentists – it's that many of the dentists aren't in the insurance networks because insurance companies deliberately keep their networks small to maximize profits, and force patients to go out-of-network. The author continues that current law does not require insurance companies to directly cover out-of-network dental services. Instead, the author states that patients must pay the full cost upfront and then seek reimbursement from their insurer. The author argues that this means patients are responsible for covering the entire bill at the time of their visit, placing the financial burden squarely on them. The author concludes that this bill will stop insurance companies from intentionally making it too difficult for families to

use their dental insurance by requiring insurers to ensure that insurance payments go directly to the dentist, so patients aren't burdened with large upfront costs.

2) BACKGROUND.

a) Dental insurance. According to the California Health Benefits Review Program (CHBRP), the majority of dental benefit plans are "fully insured" and regulated at the state level by DMHC or CDI. The Patient Protection and Affordable Care Act helped California expand Medi-Cal eligibility and offer dental benefits to newly eligible adult enrollees (the "expansion population"). Additionally, all Covered California health insurance plans offer embedded pediatric dental coverage at no extra cost. For adults, a dental plan can be added to health plan purchases. Some private-sector dental plans are referred to as "ERISA" plans, after the federal Employee Retirement Income Security Act, which governs them. States are preempted from enforcing laws on ERISA self-insured plans, but states are not barred from regulating state-licensed, fully insured health plans that may contract with ERISA plans.

Dental insurance commonly divides oral health services into the following categories: preventive and diagnostic, basic restorative services, major restorative services, and orthodontics. Preventive and diagnostic services are typically the most generous in terms of coverage. Basic restorative services include the treatments for common dental problems and are generally straightforward and nonsurgical in nature, such as simple extractions and basic root canals. Major restorative services, however, are often complex or lengthy, typically requiring more time and expense than basic services. Coverage for major restorative services can be limited in many dental plan designs and products.

Dental plans, like health plans, come in various models including Preferred Provider Organization (PPO) plans. In a PPO arrangement, the health insurer contracts with a network of providers who agree to accept lower fees and/or to control utilization. Enrollees in a PPO plan receive a higher level of benefits if they go to a preferred provider than if they go to a non-preferred or non-contracted provider.

b) AOB. A core function of dental insurance is the development of a network of dental providers who agree to treat patients covered by the plan. Dentists who contract with a dental plan will agree to terms about reimbursement rates, cost-sharing, benefits covered, and other details. Contracting dentists are then listed as a participating provider by the insurance plan and have access to the patient network covered by the plan. Contracting dentists are also able to bill the dental plan directly for services while patients are responsible for paying any cost-sharing amounts detailed under their coverage.

Patients under a PPO plan may seek services from non-contracted providers. The patients may seek an AOB, which is an arrangement where a patient requests that their plan payments be made directly to a designated person or facility, such as a dentist, physician, or hospital. In the context of this bill, an AOB would apply to non-contracting dentists. Under AOB, a patient may permit a non-contracting dentist to bill the dental plan directly and collect authorized reimbursement from the plan. The patient is on the hook to pay the dentist the remaining balance of their bill. Under AOB non-contracting, dentists aren't

required to limit their rates to contractual levels, meaning the patient may pay higher cost-sharing amounts. For example, a plan may cover a filling for $100 with the patient paying 20%. A contracted dentist would then be able to collect $80 from the plan and $20 from the patient. However, if that patient had an AOB with a non-contracting dentist who charges $150 for a filling, the dentist would collect $80 from the dental plan and $70 from the patient. If an AOB was not in place, the dentist would not be able to directly bill the insurer, meaning the patient would be balance billed for the full $150 and have to seek reimbursement for $80 from their dental plan.

c) Network Adequacy Requirements. Network adequacy standards are utilized to ensure that plans contain and maintain a network of providers adequate for enrollees to access medically necessary care in a timely manner. In California, state law sets forth various network adequacy requirements on plans and insurers, including the following:

i) Timely Access to Care. State law requires that plans meet a set of standards which include specific time frames under which enrollees must be able to access care. These requirements generally provide dental plan members the right to appointments within the following time frames:

(1) Urgent care **within 72 hours**;

(2) Non-urgent care **within 36 business days**; and,

(3) Preventive dental care **within 40 business days**.

For comparison, health plan members have the right to appointments within the following time frames:

(1) Urgent care without prior authorization: **within 48 hours**;

(2) Urgent care with prior authorization: **within 96 hours**;

(3) Non-urgent primary care appointments: **within 10 business days**;

(4) Non-urgent specialist appointments: **within 15 business days**;

(5) Non-Urgent mental health (MH) appointments: **within 15 business days** for psychiatrist, **within 10 business days** for non-physician MH provider; and,

(6) Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition: **within 15 business days**.

ii) Geographic Access. Health plans are also generally required to ensure geographic access, meaning there are a sufficient number of providers located within a reasonable distance from where each enrollee lives or works. For example, primary care physicians (PCPs) and hospitals should be **located within 15 miles or 30 minutes** from work or home.

Health plans must also ensure provider capacity such that health plan networks have enough of each of the right types of providers to deliver the volume of services needed. For example, plan networks should include **one primary care provider for every 2,000 beneficiaries**.

3) **SUPPORT.** The California Dental Association (CDA), sponsor of this bill, states that due to limited in-network options, many patients are forced to seek care from out-of-network providers. CDA continues that a common frustration is that some dental plans refuse to honor a patient's AOB, which allows patients to direct their dental benefits to their out-of-network dentist, enabling the dentist to handle payment directly. CDA states that most medical insurance plans honor AOB requests, but some dental plans do not, often requiring patients to pay for care upfront, leaving them with significant out-of-pocket costs. CDA argues that patients should not be penalized for choosing to see an out-of-network dentist, especially when their plan fails to provide an adequate network. CDA continues that regulators need a full and comprehensive view of all dental plan enrollees using a provider network to determine whether the plan is effectively meeting the needs of policyholders. CDA argues that due to these "blind spots," the state cannot fully evaluate whether dental plans offer enough in-network dentists and specialists to deliver the promised care.

4) **OPPOSITION.** The California Association of Dental Plans (CADP) opposes this bill, stating that the new requirements and mandates could increase consumers costs, reduce dental networks, and negatively impact access to affordable dental care. CADP believes the dental network reporting provisions in this bill are unnecessary and duplicative as current statutes and regulations already require dental plans to submit thorough and extensive dental network and access information to regulators to review and approve dental networks for Californians. CADP continues that while AOB can be appropriate in certain arrangements, a statutory mandate eliminates flexibility and restricts the ability of private parties to structure insurer/provider relationships that best meet their operational and financial needs. CADP further argues that the predetermination and prior authorization language in the bill is unclear if it applies only to out-of-network providers or all dental network providers.

5) **PREVIOUS LEGISLATION.**

   a) AB 371 (Haney) of 2025, was substantially similar to this bill. AB 371 was held on the Assembly Appropriations Committee suspense file.

   b) SB 386 (Limón), Chapter 219, Statutes of 2025, requires a health plan and health insurer covering dental services that provides payment directly to a dental provider to have a default method of payment that does not require the dental provider to incur a fee to access payment. Requires a health plan and health insurer to obtain affirmative consent from a dental provider who opts in to a fee-based payment method (where the provider incurs a fee to access payment) before the plan or vendor provides a fee-based payment method to the provider.

   c) AB 1048 (Wicks), Chapter 557, Statutes of 2023 prohibits, after January 1, 2025, a plan or health insurer from issuing, amending, renewing, or offering a plan contract or policy that imposes a dental waiting period provision in large group contracts and policies, or a

preexisting condition provision in any contracts or policies. Requires health plan contracts and insurance policies covering dental services to be subject to premium rate reviews.

d) SB 221 (Wiener), Chapter 724, Statutes of 2021, codifies existing timely access to care standards for health plans and insurers, applies these requirements to Medi-Cal Managed Care plans, and adds a standard for non-urgent follow-up appointments for nonphysician MH care or substance use disorder (SUD) providers that is within 10 business days of the prior appointment.

e) SB 855 (Wiener), Chapter 151, Statutes of 2020, revises and recasts California's Mental Health Parity provisions, and requires a health plan contract or disability insurance policy issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of MH and SUD, as defined, under the same terms and conditions applied to other medical conditions and prohibits a health plan or disability insurer from limiting benefits or coverage for MH and SUD to short-term or acute treatment. Specifies that if services for the medically necessary treatment of a MH and SUD are not available in network within the geographic and timely access standards in existing law, the health plan or insurer is required to arrange coverage to ensure the delivery of medically necessary out of network services and any medically necessary follow up services, as specified.

f) SB 964 (Hernandez), Chapter 573, Statutes of 2014, requires a health plan to annually report specified network adequacy data to DMHC as a part of its annual timely access compliance report, and requires DMHC to review the network adequacy data for compliance.

g) AB 1579 (Campos) of 2012, would have required a health plan or health insurer that pays a contracting dental provider directly for covered services rendered to an enrollee or insured to also pay a non-contracting dental provider directly for covered services rendered to an enrollee or insured where the provider submits a written assignment of benefits signed by the enrollee or insured, or their legal representative. AB 1579 was held in the Senate Health Committee.

h) AB 2179 (Cohn), Chapter 797, Statutes of 2002, requires DMHC and CDI to develop and adopt regulations to ensure that enrollees have access to needed health care services.

6) POLICY COMMENT.

a) Market and consumer considerations. Some opposing groups argue that the ability to receive direct payment for covered services is the primary reason dentists choose to participate in carrier networks, agreeing to lower their fees in exchange for streamlined reimbursement. Delta Dental estimates that the AOB provisions of this bill could lead to a 5% to 15% reduction in network participation, which would mean enrollees would face an additional $250 million to $700 million in out-of-pocket costs annually. However, the true impact of an AOB mandate is unclear. In their position letter on a prior iteration of

this bill, CADP stated that many of their members already offer AOB as a business decision, although they argue that it should not be mandated for all plans.

The author and sponsors shared a report with the committee from the George Washington University (GWU) titled "Analysis of the Impact of Dental AOB Laws," which was published after multiple states passed their own AOB laws. The GWU report examined the impact of AOB laws on the number of total dentists participating in PPO networks in four states, Tennessee, New Jersey, Mississippi, and South Dakota. The report found that the number of total participating dentists in PPO networks did not decline, but actually rose following the adoption of AOB laws. Delta Dental provided data on the impact of AOB laws on their networks in other states that have passed similar laws. The data provided shows that in the 13 states with their lowest network participation, eight require AOB by law. Delta Dental argues this demonstrates a correlation between AOB mandates and dentists' decisions not to participate in dental networks.

It's important to note that if an AOB mandate were to be enacted, patients would no longer be burdened with passing payment between their dental plan and provider. Removing patients from the middle of such transactions would align with recent state and federal efforts to limit patient exposure to surprise billing. When a consumer enrolls in a PPO they are generally making a conscious choice to pick a plan with more flexibility to see out-of-network providers, even if it costs more. While some opposition groups have noted that this bill erodes consumer protections, this bill does not give PPO consumers any more ability to see an out-of-network provider than they already have. In fact, this bill would provide consumers with more disclosure and notification about the cost impact of going out-of-network than they would without an AOB. Making these trade-offs clearer to patients should be considered a step forward. While the impact of AOB on the dental plan market is an important consideration that the Legislature should continue to question, it is important to also center the patient experience when considering the context of this bill. Opposition groups have argued that further consumer protections could be included, such as capping the rate that out-of-network providers can charge a consumer. Given that the author's goal is to reduce cost burden on consumers, they may wish to consider such provisions if this bill moves forward.

b) **Implementation hurdles**. As drafted, this bill requires CDI and DMHC to enforce provisions against entities they don't have regulatory authority over. For example, this bill requires CDI to collect information from DMHC-regulated, Med-Cal, self-funded, and potentially, ERISA-regulated plans. It also requires DMHC to collect information from CDI-regulated, Medi-Cal, self-funded, and potentially, ERISA-regulated plans. While both entities have full statutory power to enforce reporting provisions on dental plans under their respective jurisdiction, it is unclear what authority they would have to compel and enforce such provisions on plans regulated by other entities. Additionally, this bill requires CDI and DMHC to ensure that out-of-network dentists are complying with the consumer notification pieces of this bill. One of the regulators flagged that they can enforce provider requirements through an insurer/plan contract with the provider. However, under the provisions of this bill there is no provider contract in place, therefore there is no enforcement mechanism for them to compel dentists to comply with these requirements. The author may wish to work with CDI and DMHC to ensure that

these provisions are enforceable, otherwise this legislation may not accomplish the author's goals.

REGISTERED SUPPORT / OPPOSITION:

Support

California Dental Association (sponsor)
American Federation of State, County and Municipal Employees, AFL-CIO
California Academy of General Dentistry
California Association of Oral and Maxillofacial Surgeons
California Association of Orthodontists
One individual

Oppose

Association of California Life & Health Insurance Companies
Bay Area Council
California Association of Dental Plans
California Association of Health Plans
California Chamber of Commerce
Delta Dental of California
Los Angeles County Business Federation
San Francisco Chamber of Commerce

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