SENATE COMMITTEE ON HEALTH
Senator Akilah Weber Pierson, Chair

BILL NO: AB 1629
AUTHOR: Haney
VERSION: June 3, 2026
HEARING DATE: June 24, 2026
CONSULTANT: Teri Boughton

SUBJECT: Dental coverage

SUMMARY: Requires health plans, insurers, and specialized plans that cover dental services to certify under penalty of perjury and attest that the plan or insurer has evaluated and taken into consideration the total number of lives utilizing the same dental provider network and if those enrolled lives impact network adequacy requirements. Requires a plan or insurer to pay a noncontracting dental provider directly for covered services and pay no less than the amount set forth in a predetermination or prior authorization of services. Makes it unprofessional conduct for a noncontracting dental provider to fail to inform an enrollee or insured of certain information, including an estimate of services as part of the enrollee's or insured's authorization of the direct noncontracting dental provider payment from the plan or insurer (also referred to as assignment of benefits).

Existing law:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act); California Department of Insurance (CDI) to regulate health and other insurance; and the Department of Health Care Services (DHCS) to administer the Medi-Cal program. [HSC §1340, et seq., INS §106, et seq., and WIC §14000, et seq.]

2) Requires health plans and insurers that provide or arrange for the provision of hospitals or physician services, including specialized mental health plans and policies, to comply with timely access requirements, including in a timely manner appropriate for the nature of the condition consistent with good professional practices. Requires plans and insurers to maintain networks and policies consistent with this clinical appropriateness standard; and, to ensure its network has capacity and availability to offer appointments that meet the following timeframes, unless the provider has determined and noted in the record that a longer waiting time is not detrimental:
   a) Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment;
   b) Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment;
   c) Nonurgent appointments for primary care: within 10 business days of the request for appointment;
   d) Nonurgent appointments with specialist physicians: within 15 business days of the request for appointment; and,
   e) Nonurgent appointments with a nonphysician mental health care or substance use disorder provider: within 10 business days of the request for appointment. [HSC §1367.03 and INS §10133.54]

3) Requires each dental plan and each full service plan offering coverage for dental services to comply with the clinical appropriateness standard described in 2) above; and to have

networks and adequate capacity and availability of providers to offer appointments for covered dental services in accordance with the following requirements:

a) Urgent appointments within the dental plan network offered within 72 hours of the time of request for appointment, if consistent with the enrollee's individual needs and as required by professionally recognized standards of dental practice;
b) Nonurgent appointments offered within 36 business days of the request for appointment, unless it is a preventive dental care appointment subject to c) below; and,
c) Preventive dental care appointments offered within 40 business days of the request for an appointment.

Permits applicable waiting times to be extended if the provider has determined and noted in the patient's record a longer waiting time will not be detrimental consistent with professionally recognized standards of practice. [HSC §1367.03 and INS §10133.54]

4) Requires contracts between health plans and providers to ensure compliance with Knox-Keene Act standards and requires reporting by providers to plans and by plans to DMHC. Requires plans to file annual compliance reports. Authorizes CDI to review and adopt standards concerning the availability of providers so that consumers have timely access to care. Authorizes CDI to take compliance or disciplinary action, including imposition of administrative penalties. [HSC §1367.03 and INS §10133.54]

5) Requires a disability insurer, upon written consent of the insured, to pay group insurance benefits contingent upon, or for expenses incurred, for hospitalization, medical, or surgical aid to the person or persons furnishing the hospitalization, medical, or surgical aid, or, to the person having paid for the services, an amount not to exceed the amount of benefit provided by the policy with respect to the service or billing of the provider. Prohibits the amount of the payments pursuant to one or more assignments from exceeding the amount of expenses incurred. Requires payments so made to discharge the insurer's obligation with respect to the amount so paid. Permits an insurer to negotiate and enter into contracts for alternative rates of payment with institutional providers and professional providers. [INS §10133]

6) Requires a disability insurer to pay group insurance benefits contingent upon, or for expenses incurred for hospitalization of medical or surgical aid to the person or persons having provided or having paid for the hospitalization or medical or surgical aid when specified items are submitted including a provider's itemized bill for services, name address of the person to be reimbursed, the policy number of insured, a signature verifying services being billed have been provided, and other necessary information directly related to coverage under the policy. [INS §10133.7]

7) Requires a disability insurer or health plan to pay group insurance benefits to DHCS for expenses incurred for hospitalization, medical, or surgical aid in the case of a Medi-Cal beneficiary. Requires every group health plan that provides hospital, medical, or surgical expense benefits for plan members and their dependents to authorize and permit assignment of an enrollee's or subscriber's right to any reimbursement for health care service covered under contract with DHCS when health care service are provided to a Medi-Cal beneficiary, except as specified. [INS §10133.7 and HSC §1371.3]

8) Requires a health plan, including a specialized plan, and health insurance policies that cover hospital, medical or surgical expense to reimburse a complete claim for emergency services or portion thereof as soon as practicable but no later than 30 calendar days after receipt of the

claim, as specified, whether the claim is in state or out of state. [HSC §1371 and §1371.35; INS §10123.13 and §10123.147]

9) Requires every contract between a plan and health care provider to be in writing and set forth that in the event the plan fails to pay for health care services set forth in the subscriber contract, the subscriber or enrollee is not to be liable to the provider for any sums owed by the plan. Prohibits, if the contract has not been reduced to writing, or if the contract fails to contain the required prohibition, the contracting provider from collecting or attempting to collect from the subscriber or enrollee sums owed by the plan. Prohibits a contracting provider, agent, trustee, or assignee thereof, from maintaining any action at law against a subscriber or enrollee to collect sums owed by the plan. [HSC §1379]

10) Establishes criteria for unprofessional conduct for persons licensed under the Dental Practices Act. [BPC §1680]

This bill:

Network Adequacy

1) Requires a health plan that issues, sells, renews, or offers a plan contract covering dental services, including a specialized health plan covering dental services, to certify, under penalty of perjury, that information and data submitted to DMHC as required by law is true and correct, as referenced in regulations, as specified. Requires an insurer that issues, sells, renews, or offers a policy of health insurance, as defined, covering dental services, including a specialized health insurance policy covering dental services to certify, under penalty of perjury, that information and data submitted to CDI as required by law is true and correct.

2) Requires 1) directly above to include an attestation that, in determining and reporting on network adequacy, the plan has evaluated and taken into consideration the total number of lives utilizing the same provider network and if those enrolled lives impact network adequacy requirements. Authorizes DMHC and CDI to audit plans for compliance or in response to consumer complaints regarding network adequacy. Authorizes DMHC and CDI to adopt additional standards consistent with existing law.

Assignment of benefits

3) Requires a health plan or insurer that pays a contracting dental provider directly for covered services rendered to an enrollee or insured, to also pay a noncontracting dental provider directly for covered services rendered to an enrollee or insured if the noncontracting provider submits to a written assignment of benefits form signed by the enrollee or insured. Defines "assignment of benefits" as the transfer of reimbursement or other rights provided for under a health plan contract or health insurance policy to a treating provider for services or items rendered to an enrollee or insured.

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

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

6) Applies the assignment of benefits provisions to a health plan contract or health insurance policy covering dental services or a specialized health plan contract or policy covering dental services. Exempts Medi-Cal managed care plan contracts, including dental managed care contracts.

Business and Professions provisions

7) Makes it unprofessional conduct for a person licensed under the Dental Practice Act to fail to provide an enrollee or insured with the following disclosures before accepting an assignment of benefits, if the licensee is not under contract with the dental benefit plan:
   a) That the licensee is a noncontracting dental provider with respect to the enrollee's or insured's dental benefit plan;
   b) That the enrollee or insured may experience lower out-of-pocket costs if services are rendered by a dentist who is under contract with the dental benefit plan; and,
   c) An estimate of the planned treatment cost and the enrollee's or insured's portion of that cost.

FISCAL EFFECT: As amended, this bill has not been analyzed by a fiscal committee.

PRIOR VOTES:

Assembly Floor:	61 - 0
Assembly Appropriations Committee:	11 - 0
Assembly Health Committee:	12 - 0

COMMENTS:

1) *Author's statement.* 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. California has over 35,000 active dentists, which is the most in the nation. 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. Current law does not require insurance companies to directly cover out-of-network dental services. Instead, patients must pay the full cost upfront and then seek reimbursement from their insurer. This means patients are responsible for covering the entire bill at the time of their visit, placing the financial burden squarely on them. 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*. Regulation and oversight of health insurance in California is split between two state departments. DMHC regulates 97% of state-regulated commercial and public health plan enrollment. Specifically, DMHC regulates health plans under Knox-Keene Act, which includes health maintenance organizations (HMOs) and some Preferred Provider Organization (PPO) plans. CDI regulates health insurers offering health insurance, which includes PPO plans and traditional indemnity insurance. An HMO is a managed care arrangement that provides and arranges for health care through contracted or employed providers and generally only covers health services provided by network providers, except in an emergency. In a PPO arrangement, the plan or insurer contracts with a network of medical providers who agree to accept lower fees and/or to control utilization. Enrollees in a PPO

plan have the option to obtain care from a provider that is out of the PPO network but generally pay a higher cost in doing so. Many plans and insurers that cover dental benefits are licensed as specialized plans but there are some full service health plans and insurers that also cover dental services.

3) *Timely access compliance and annual network reporting*. Health plans are required to annually submit to DMHC information confirming the status of each of their networks and enrollment, including a complete list of the health plan's network providers, hospitals and other facilities, and enrollees. By May 1st of each year, reporting plans (full-service health plans and specialized plans that provide mental health services) are required to report to DMHC information regarding their compliance with timely access standards and network adequacy requirements. Also, by May 1st of each year, profile-only plans (e.g., restricted and limited full-service, subcontracted, dental, vision, acupuncture, and chiropractic health plans) are required to annually submit to the DMHC network profile information detailing their approved network names, product lines, network service area, enrollment status, and plan-to-plan contracts. According to the 2024 DMHC annual report, one of DMHC's top priorities is to ensure health plan members can access health care services when they need it. In 2024, DMHC reviewed annual timely access compliance reports submitted by health plans, including provider appointment availability surveys, for Measurement Year 2023. Plans that do not meet timely access standards must submit corrective actions to DMHC and, in certain circumstances, may be subject to disciplinary action. In addition to monitoring health plan networks for compliance with timely access standards, DMHC reviews most health plan networks for compliance with network adequacy requirements on an annual basis. DMHC developed new network adequacy regulations which revised standards and methodologies for 2024 to improve network monitoring through the annual review.

4) *Assignment of benefits.* Assignment of benefits refers to an arrangement where a patient requests that their health benefit payments be made directly to a designated provider or facility, such as a physician or hospital. Health plans regulated by DMHC, which include HMOs and PPOs are required to directly reimburse providers for emergency care and services, providing certain statutory and regulatory conditions are met. Otherwise, HMO model plans would generally have no legal obligation to reimburse non-contracted providers, except in an emergency, since the plan contract provides that enrollees must get services from network providers in order for the benefits to be covered. DMHC regulations require a plan to arrange for out-of-network care for covered services if care cannot be provided within timely access requirements in network, and in those cases cost-sharing cannot exceed applicable in network cost-sharing. For both DMHC and CDI regulated plans and insurers, mental health or substance use disorder services that are not available within geographic and timely distance standards must also be covered at in network cost-sharing when provided by out-of-network providers.

   PPO enrollees may seek services from non-contracted providers. PPOs have historically reimbursed enrollees directly for covered services, but have generally allowed for assignment of benefits to network providers, and even for out-of-network providers. If a patient signs a written authorization, the provider may seek, and the insurer must pay, the provider directly. Patients are still liable for their share of costs, which can be substantial for a provider outside the PPO network. For example, a PPO policy might pay 80% of the negotiated rate for contracted providers and the patient pays the remaining 20% of that negotiated rate. For non-contracted providers, the policy might only pay 60% of what the carrier determines is the usual and customary fee and the patient is liable for the difference between what the insurer

paid and the provider's billed charges, which might be higher than usual and customary fees. Even where the patient assigns the benefits to the provider, unless the provider waives the right to payment, the patient remains liable for full payment to the provider. In addition to the added cost to the patient for going to an out-of-network provider, a PPO may exclude amounts the patient pays to out-of-network providers for covered services from application toward the deductible and annual maximum copayment limits.

5) *Double referral.* This bill is double referred. Should this bill pass this committee it will be referred to the Senate Committee on Business, Professions, and Economic Development.

6) *Prior legislation.* AB 371 (Haney of 2025) would have required a health plan or 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 form signed by the enrollee. AB 371 would have required a health plan or insurer offering dental services to meet specified timely and geographic access requirements. *AB 371 was held in the Assembly Appropriations Committee.*

AB 72 (Bonta, Chapter 492, Statutes of 2016) establishes a payment rate, which is the greater of the average of a health plan or health insurer's contracted rate, as specified, or 125% of the amount Medicare reimburses for the same or similar services; and an independent dispute resolution process for claims and claim disputes related to covered services provided at a contracted health facility by a noncontracting individual health care professional. AB 72 limits enrollee and insured cost-sharing for these covered services to no more than the cost sharing required had the services been provided by a contracting health professional.

AB 1086 (Dababneh of 2015) would have required health plans and insurers that sell products in the individual market to authorize and permit assignment of benefits for covered services to a non-contracting physician who furnishes health care services. *AB 1086 failed passage in the Assembly Health Committee.*

SB 1373 (Lieu of 2012) would have required hospitals to provide an enrollee or insured, who seeks services at a hospital for an elective or scheduled procedure, a notice with specified information, further requires a plan to either refer the enrollee or subscriber to a contracting provider or authorize the person to obtain services from a noncontracting provider. *SB 1373 failed passage in the Senate Health Committee.*

AB 1579 (Campos of 2012) would have required a health plan or insurer that pays a contracting dental provider directly for covered services rendered to an enrollee or insured to also pay a noncontracting 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 contained a very specific disclosure notice with a translation requirement that indicated the provider is out-of-network and the plan's benefits and policies may not apply, out-of-pockets costs may be higher, how to find an in-network provider and confirm dental benefit information. AB 1579 also contained written estimates and balanced billing protections for the enrollee. *AB 1579 was not heard in the Senate Health Committee.*

AB 1742 (Pan of 2012) would have required health plans and individual insurers, except specialized health plans and insurers, to permit enrollees to assign benefits directly to health

care providers for health care services. *AB 1742 failed passage in the Assembly Health Committee.*

AB 2275 (Hayashi, Chapter 673, Statutes of 2010) prohibits a provider from charging more for non-covered dental services than his or her usual and customary rate for those services.

AB 1455 (Scott, Chapter 827, Statutes of 2000) bars health plans from engaging in unfair payment patterns in the reimbursement of providers. AB 1455 contains a number of other provisions regarding payment practices of health plans, including requiring health plans to make their dispute resolution process available to noncontracting providers.

AB 2309 (Woodruff, Chapter 744, Statutes of 1993) requires health plans and insurers that cover the expenses of health care services to permit the insured or covered person to assign reimbursement to the provider of services, in which case the insurer is required to directly pay the provider, custodial parent, or DHCS for Medi-Cal beneficiaries.

7) *Support.* The California Dental Association (CDA), the sponsor of this bill, writes Californians are increasingly finding it difficult to find in-network dentists, not because of a shortage of dentists, but as a result of dental plans offering inadequate networks, forcing patients to seek care out-of-network. CDA indicates most medical plans honor assignment of benefits, but some dental plans refuse, requiring patients to pay upfront, leaving them with significant out-of-pocket costs. CDA also writes that recent amendments removed reporting requirements and instead require attestation that plans have considered all dental plans offered when they file for network adequacy review. CDA says this seeks to remove substantial costs from this bill. The California Academy of General Dentistry indicates many plans and insurers do not have contracted providers that are reasonably accessible to their enrollees due to distance or transportation issues. The California Association of Oral and Maxillofacial Surgeons writes that patients often choose to seek care outside of their insurance network for a variety of reasons, including continuity of care, provider availability, or personal preference, and, when they make that choice it is essential that the process for assigning benefits and receiving reimbursement is straightforward and that patients and providers have clarity about how coverage will be applied. The California Association of Orthodontists (CAO) writes that half of Californians with commercial dental plans have a plan that is self-insured by their employer and regulated under federal law. CAO says because they are outside of state regulatory oversight, they are not included in network adequacy assessments, despite serving a significant number of patients, and state 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. The California Hospital Association (CHA) writes that this bill ensures patients can access preventive care, including dental services, which is vital to improving overall health outcomes and preventing unnecessary emergency department visits related to dental pain. CHA says this bill would increase access and transparency by improving state oversight of dental plans' network adequacy and require dental plans to honor assignment of benefits requests from enrollees.

8) *Opposition.* The California Association of Dental Plans (CADP) writes that this bill requires dental plans to affirm duplicative and burdensome dental provider network data and mandates assignment of benefit for dental plans which could increase consumer costs, reduce dental networks, and negatively impact access to affordable dental care for Californians. CADP believes this bill includes reporting for plans not regulated by the state and suggests they already have to comply with extensive dental network and access reporting requirements

and are not seeing significant complaints regarding access to providers. Regarding assignment of benefits, CADP believes this bill interferes with legitimate business decisions and oversight, and patient protections exist within network contracts. However, if this remains in this bill, CADP suggests removing the clause "when a health care service plan pays a contracting dental provider directly for covered services rendered to an enrollee." Additionally, CADP identifies problems with the use of pre-determinations and prior authorizations suggested in this bill that result in a two-tiered provider system that will disincentivize network participation, and suggests allowing other reasonable factors identified by the National Council of Insurance Legislators model and other state legislation to be used to impact payment such as if the annual maximum or other benefit limitations have been reached, or if another payer is responsible for payment. The California Association of Health Plans (CAHP) and the Association of California Life and Health Insurance Companies (ACLHIC) believe the use of predeterminations and prior authorization in this bill is one of the most significant issues, as they are preliminary information and not required before services are rendered, do not constitute binding coverage determinations, and are expressly subject to final claim adjudication. CAHP and ACLHIC indicate that obtaining direct reimbursement is one of the key advantages of being a participating provider and if direct payment is required it will impact their networks and consumer protections required of contracted plans. Delta Dental writes that this bill threatens to increase consumer costs, weaken dental provider networks, and reduce access to affordable dental care, and it fails to address any documented problem or issue in the California dental marketplace, which is notable for high patient satisfaction, and the small number of complaints documented by DMHC and CDI. Delta Dental says this bill would extend the benefit of network participation to nonparticipating dentists without requiring them to accept negotiated rates or comply with patient protections. Delta Dental estimates that if this bill results in even a modest 5% to 15% reduction in network participation, total out-of-pocket costs for their enrollees would increase by approximately $250 million to $740 million annually, which does not represent a loss of revenue for Delta Dental, but a direct loss for enrollees who would have to pay higher out-of-pocket costs if dentist network participation declines.

9) *Policy comments.* This bill raises network adequacy concerns on plans and insurers that cover dental services, and at the same time, arguably, incentivizes dental providers not to contract with these plans because this bill guarantees direct payment regardless of the terms of the coverage, or any of the other contractual terms that apply to contracted providers. Worthy of focus is the impact on access and affordability of dental coverage for enrollees and insureds for this coverage. If coverage includes an out-of-network benefit the plan should honor that benefit and the enrollee should be fully informed about cost differentials that may occur and contractual protections that may not apply because of the use of an out-of-network provider for services.

10) *Amendments.* The committee may wish to amend this bill to expand consumer protections and clarify provider obligations regarding assignment of benefits and simplify the assignment of benefit requirements on plans to be more consistent with the activities of plans currently honoring assignment of benefits, while obligating those plans not honoring assignment of benefits to do so.

SUPPORT AND OPPOSITION:

Support: California Dental Association (sponsor)
American Federation of State, County and Municipal Employees
California Academy of General Dentistry

California Association of Oral and Maxillofacial Surgeons
California Association of Orthodontists
California Dental Hygienists' Association
California Hospital Association
California Medical Association
Dental Hygiene Board of California
San Francisco Marin Medical Society

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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