SENATE COMMITTEE ON
BUSINESS, PROFESSIONS AND ECONOMIC DEVELOPMENT
Senator Dr. Aisha Wahab, Chair
2025 - 2026 Regular

Bill No:	AB 1629	**Hearing Date:**	June 29, 2026
Author:	Haney		
Version:	June 25, 2026		
Urgency:	No	**Fiscal:**	Yes
Consultant:	Yeaphana La Marr		

Subject: Dental coverage

SUMMARY: 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 upon written and dated consent of the enrollee. Makes it unprofessional conduct for a noncontracting dental provider who fails to provide a health plan enrollee, specialized health plan enrollee, or insured specified disclosures, including an estimate cost of services and the enrollee's portion of that cost. 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.

NOTE: *This bill is double-referred. It was previously heard in the Senate Committee on Health on June 24, 2026, and passed with a vote of 9-2.*

Existing law:

1) Establishes the Dental Board of California (DBC) to regulate the practice of dentistry and to administer and enforce the Dental Practice Act (Act). (Business and Professions Code (BPC) §§ 1600 et seq.)

2) Provides that protection of the public shall be the highest priority for the DBC in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount. (BPC § 1601.2)

3) Authorizes the DBC to inspect the books, records, and premises of any dentist licensed under the Act and the licensing documents, records, and premises of any dental assistant permitted under the Act in response to a complaint that a dentist or dental assistant has violated any law or regulation that constitutes grounds for disciplinary action by the board. (BPC § 1611.5)

4) Establishes criteria for unprofessional conduct for persons licensed under the Dental Practice Act. (BPC §1680)

5) Specifies that any license may be revoked or suspended or the licensee may be reprimanded or be placed on probation by the DBC for unprofessional conduct, and other specified causes provided by the Act. (BPC § 1670)

6) 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). (Health and Safety Code (HSC) §1340, et seq.)

7) Establishes the California Department of Insurance (CDI) to regulate health insurance; defines health insurance as "an individual or group disability insurance policy that provides coverage for hospital, medical, or surgical benefits"; and defines "specialized health insurance policy" as a policy of health insurance for covered benefits in a single specialized area of health care, including dental-only, vision-only, and behavioral health-only policies. (Insurance Code (INS) §§100, et seq., 100(b),(c))

8) Requires health care service 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(a)(5) and INS §10133.54(b)(5))

9) Requires each dental plan and each full-service plan offering coverage for dental services to comply with the clinical appropriateness standard described in 7) 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(a)(6) and INS §10133.54(b)(6)(B))

10) Requires contracts between health care service plans and health care providers to ensure compliance with standards developed under the Knox-Keene Act. Requires compliance reporting by health care providers to health care service plans and by health care service plans to the DMHC. Requires health care plans to annually file compliance reports with the DMHC. Requires DMHC to develop standardized methodologies for reporting to be used by health care service plans to demonstrate compliance with accessibility standards appropriate for the enrollee's condition. Authorizes DMHC to take disciplinary action, including assessment of civil penalties for noncompliance. (HSC § 1367.03(f))

11) Authorizes CDI to issue guidance to insurers regarding annual timely access and network reporting methodologies, exempt from requirements of the Administrative Procedure Act; authorizes CDI to take disciplinary action, including assessment of civil penalties for noncompliance of 9). (INS § 10133.54(f))

12) Defines "health insurer" as an insurer that issues, sells, renews, or offers a policy of health insurance covering dental services, including a specialized health insurance policy covering dental services. (INS § 10120.41(a)(2))

This bill:

1) States findings and declarations, including the intent of the Legislature to hold dental plans and insurers accountable for meeting network adequacy requirements.

2) Classifies failure of a dentist to comply with disclosure requirements required by this bill as unprofessional conduct, enforceable by the DBC.

3) Requires a health care service plan covering out-of-network dental services or a specialized health care service plan covering out-of-network dental services to pay a noncontracting dental provider directly for covered services rendered to an enrollee in accordance with the benefit provided in the enrollee's contract upon written and dated consent of the enrollee.

4) Requires a dental provider to disclose all of the following before accepting an assignment of benefits:

a) That the licensee is a noncontracting dental provider with respect to the enrollee's dental benefit plan.

b) That the enrollee may experience lower out-of-pocket costs if services are rendered by a dentist who is under contract with the dental benefit plan.

c) An estimate of the planned treatment cost and an estimate of the enrollee's portion of that cost or a deposit that approximates cost share.

d) That the enrollee's plan benefits may not apply to the treatment, and the noncontracting dental provider is not subject to contract requirements of the enrollee's dental benefit plan.

e) That the enrollee has the right to confirm their dental benefit or coverage information from their plan before beginning treatment.

f) That an agreement to assignment of benefits is optional and may be revoked with respect to services not yet rendered by contacting in writing the noncontracting dental provider and health care service plan covering dental services or the specialized health care service plan covering dental services.

5) Prohibits the noncontracting dental provider from charging the enrollee prior to the plan payment more than an estimate of the enrollee's cost sharing for the treatment or a deposit that approximates the enrollee's cost share.

6) Classifies a health care service plan covering dental services and a specialized health care service plan covering dental services as a third-party payor under BPC § 732 for the purposes of payment for services rendered that must be refunded within specified timeframes by a physician and surgeon or a dentist. A violation is considered unprofessional conduct.

7) Defines "assignment of benefits" as the transfer of reimbursement or other rights provided for under a health care service plan contract to a treating provider for services or items rendered to an enrollee for the purposes of 3) – 6).

8) Adds corresponding language to the Insurance Code to implement the same requirements as 3) – 7), but applicable to a health insurance policy covering dental services or specialized health insurance policy covering dental services.

9) Requires a health care service plan to certify, under penalty of perjury, that information and data submitted to the DMHC above in 10) is true and correct and 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 by allowing consumers to compare the performance of plans and their network providers in complying with standards of the Knox-Keene Act; authorizes the DMHC to audit plans for compliance and in response to consumer complaints regarding network adequacy; authorizes DMHC to adopt additional standards to improve timely access to care and network adequacy.

10) Requires a health insurer to certify, under penalty of perjury, that information and data submitted to the CDI is true and correct and include an attestation that, in determining and reporting on network adequacy, the insurer has evaluated and taken into consideration the total number of lives utilizing the same provider network and if those enrolled lives impact network adequacy; authorizes CDI to adopt additional standards to improve timely access to care and network adequacy.

FISCAL EFFECT: This bill is keyed fiscal by Legislative Counsel. According to the Assembly Committee on Appropriations, "CDI estimates costs of $224,000 in fiscal year (FY) 2026-27, $222,000 in FY 2027-28, and $356,000 in FY 2028-29 and ongoing (Insurance Fund) to amend network adequacy regulations, review policy forms, and expand network adequacy reviews. CDI reports it currently reviews only specialized health insurance policies that provide pediatric essential health benefit dental care for network adequacy; this bill requires CDI to review all specialized health insurance policies that provide dental coverage. Costs to DMHC of an unknown amount. However, assuming DMHC's costs to implement this bill would be similar to those for AB 371 (Haney), of the current legislative session, costs to DMHC could be in the millions of dollars per year (Managed Care Fund)."

COMMENTS:

1. **Purpose.** This bill is sponsored by the California Dental Association. 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.

   AB 1629 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.**

   Network adequacy issues. In California, an estimated 5.2 million residents lack consistent access to a dentist. Many patients are required to travel long distances for care or pay high out-of-pocket costs because provider networks are too narrow and restrictive. Delayed dental care can lead to serious health risks and is known to disproportionately harm low-income and underserved communities where provider shortages are more severe. The Center for Disease Control (CDC) reports that 67% of dental health professional shortages are in rural communities. The Harvard Gazette

According to the DCA 2024-25 Annual Report, California has nearly 36,000 active dentist licensees. The Author states, “The issue is not a shortage of dentists; it is that many are not included in insurance networks because insurers keep networks small to control costs and maximize profits, forcing patients out of the network.”

Currently, if a patient does not have access to a dentist within their network, or if they cannot get an appointment because of excessive wait times, they might turn to an out-of-network dentist at their own cost. Others delay dental care or go without at the expense of their overall health. When preventative care is delayed, it often leads to more costly restorative care and worse, untreated dental issues have been linked to diabetes and heart disease.

This bill would require health plans and insurers to pay an out-of-network dentist for services provided to an enrollee or insured patient upon written consent of the patient. The goal of this bill is to increase access to care by allowing a patient to visit an out-of-network dentist without being required to pay the upfront costs themselves, although they will eventually have to pay any difference in what the dentist charges and what the dentist is reimbursed by the health plan or insurance.

Disclosures, estimates, and unprofessional conduct. This bill would require the dentist to disclose to the patient a list of information including that the dentist is not a provider within the patient’s dental benefit plan; the patent may experience lower out-of-pocket costs if they visit a dentist who is in-network; an estimate of the planned treatment cost and an estimate of the patient’s approximate out-of-pocket costs; a statement that the patient’s benefits may not apply to the treatment being sought; and other disclosures. Failure to provide these disclosures would qualify as unprofessional conduct and subject the dentist to disciplinary action by the DBC, up to and including license revocation.

The intent and goal of this bill to increase accessibility is commendable; however, holding out-of-network dentists accountable for providing estimates to patients who are members of a health service plan or insurance plan while placing themselves at risk of disciplinary action may not serve the goal of this bill to increase the number of dentists available to patients who lack access to in-network dental care.

3. **Related Legislation.** SB 386 (Limón, Chapter 219, Statutes of 2025) requires a health plan or health insurer that provides direct payment to a dental provider, or payment through a contracted vendor, to have a non-fee-based default method of payment and obtain affirmative consent from a dental provider who opts in, prior to providing a fee-based payment.

   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; would have required a health plan or insurer offering dental services to meet specified timely and geographic access requirements. (Status: *The bill was held in the Assembly Committee on Appropriations.*)

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. (Status: *The bill did not advance from the Assembly Committee on Health*.)

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; would have required specific disclosure indicating 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; would have required written estimates and balanced billing protections for the enrollee. (Status: *the bill did not advance from the Senate Committee on Health.*)

4. **Arguments in Support.** The California Dental Association (sponsor) writes, "Because of limited in-network options, many patients are forced to seek care from out-of-network providers. A common frustration is that some dental plans refuse to honor a patient's Assignment of Benefits (AOB). AOB allows patients to direct their dental benefits to their out-of-network dentist, enabling the dentist to handle payment directly. When AOB requests are not honored, patients must pay 100% of the treatment out of pocket and then seek reimbursement from their plan. Most medical insurance plans honor AOB requests, however some dental plans do not, which presents a significant barrier to care. Across the US, 28 states currently require dental plans to honor AOB requests, and the majority of plans operating in California already do so as a matter of practice. Patients should not be penalized for choosing to see an out-of-network dentist, especially when their plan fails to provide an adequate network. AB 1629 increases access and transparency by improving state oversight of dental plans' network adequacy and requiring dental plans to honor AOB requests from enrollees. These improvements will ensure that patients receive better value and access to care from their dental coverage."

   The American Federation of State, County and Municipal Employees, AFL-CIO, writes, "This legislation streamlines the reimbursement process by requiring insurers to pay noncontracting providers directly via a signed assignment of benefits, which ensures patients are not burdened with large upfront costs when seeking out-of-network care. Furthermore, by mandating that insurers honor predeterminations and empowering state departments to conduct comprehensive reviews of dental provider networks, the bill eliminates the "bait-and-switch" financial surprises and narrow-network hurdles that currently prevent Californians from accessing timely, reliable dental services."

   The San Francisco Marin Medical Society writes, "Oral health is directly connected to overall health outcomes. Untreated dental disease can contribute to serious medical conditions, including cardiovascular disease, diabetes complications, adverse pregnancy outcomes, and infections. Improving access to dental services helps promote better health across the continuum of care. By requiring plans to pay

providers directly when patients assign benefits, AB 1629 can reduce financial and administrative obstacles that prevent patients from obtaining timely treatment."

5. **Arguments in Opposition.** The Association of California Life and Health Insurance Companies and California Association of Health Plans oppose writing, "…the bill's provision related to assignment of benefits is especially concerning as it directly undermines existing network standards and potentially subjects patients to inflated, unanticipated costs. Obtaining direct reimbursement is one of the key advantages of being a participating provider. By allowing non-contracted dentists the opportunity to receive direct payments, AB 1629 disincentivizes dentists from contracting with health plans/insurers. Reduced contracting between plans and providers means consumers will lose several advantages, including services provided at discounted rates." The organizations say that "one of the most significant issues with AB 1629 is its attempt to convert predeterminations into guaranteed payments. Currently, a predetermination and/or a pre-treatment estimate are optional tools aimed at aiding providers and patients in understanding potential coverage and cost-sharing. Specifically, they: Are not required before services are rendered; Do not constitute binding coverage determinations; and Are expressly subject to final claim adjudication. Predeterminations are based on preliminary information available at the time of review. Final reimbursement can only be determined when the claim is submitted and fully adjudicated. Payment then depends on factors such as: Patient eligibility at the time of service; Coordination of benefits; Annual or lifetime benefit caps; Frequency limitations; Claim-level edits and billing accuracy, and Changes in coverage between the estimates and date of service."

   Delta Dental of California writes, "A central concern of AB 1629 is the mandate of assignment of benefits (AOB). By requiring plans to pay non-contracted providers directly, without requiring adherence to accepted negotiated fees, compliance with contractual standards, or provided consumer protections, AOB reduces incentives for providers to participate in plan networks. Over time, this dynamic will erode network participation, limit access to in-network care, and increase the likelihood that patients receive services from out-of-network providers, exposing enrollees to higher and less predictable out-of-pocket costs, including balance billing."

6. **Policy Comments and Questions.**

   Is there value to the estimate if the estimate is not close to the share the patient will be expected to pay out of pocket? The purpose of providing an estimate is to allow the consumer to make an educated decision about their health care. A cost/benefit analysis is meaningless without knowing whether the decreased wait time associated with using an out-of-network dentist is worth the additional costs if the costs are not close to reality. Considering the variables that determine how much a provider would be paid, and therefore, how much the enrollee would be required to pay, would the dentist have the information available to provide a credible estimate to the patient? *Is the estimate intended to be calculated by the health plan and provided by the dentist or is the dentist expected to assess the above? The Author may wish to clarify who is responsible for providing the calculations for the estimate of the enrollee's portion of the cost. Considering this requirement likely cannot be met with any level of accuracy by the dentist and not meeting the requirement could*

result in license suspension or revocation, this bill may result in a reduced number of dentists, which runs counter to the purpose of this bill to increase access to care.

Conversely, are violations provable and enforceable? If a dentist gives a client a wildly off estimate, is it a violation? This bill does not provide guardrails around accuracy, which raises questions about whether protecting consumers' financial security is a priority. What would stop a dentist from always providing an estimate of $0 to stop a patient from going elsewhere? If the dentist does not give disclosures at all, is that a violation? The DBC is authorized to inspect records of its licensees in response to a complaint that licensee has violated any law or regulation that constitutes grounds for disciplinary action by the DBC. However, the only written document required by this bill is consent of the enrollee for the health care service plan to pay the noncontracting dentist. How would the DBC prove there was a violation of the disclosure requirements? *The Author may wish to consider amendments to require written disclosures signed and dated by the patient and retained by the dentist. The Author may also wish to require guardrails around what constitutes an acceptable estimate.*

SUPPORT AND OPPOSITION:

Support:

American Federation of State, County and Municipal Employees, AFL-CIO
California Dental Association
San Francisco Marin Medical Society

Opposition:

Association of California Life & Health Insurance Companies
California Association of Health Plans
Delta Dental of California

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