SENATE COMMITTEE ON APPROPRIATIONS
Senator Sabrina Cervantes, Chair
2025 - 2026 Regular Session

AB 1629 (Haney) - Dental coverage

Version: June 25, 2026
Policy Vote: HEALTH 9 - 2, B., P. & E.D. 8 - 2
Urgency: No
Mandate: Yes
Hearing Date: August 3, 2026
Consultant: Agnes Lee

Bill Summary: AB 1629 would require a health plan or insurer covering dental services to pay a noncontracting dental provider directly for covered services, as specified.

Fiscal Impact:

- The Department of Managed Health Care (DMHC) estimates costs of approximately $1,781,000 in 2027-28, $1,548,000 each year in 2028-29 and 2029-30, and $1,637,000 in 2030-31 and annually thereafter for state administration (Managed Care Fund).

- The California Department of Insurance (CDI) estimates costs of $11,000 in 2026-27 and $23,000 in 2027-28 for state administration (Insurance Fund).

- The Dental Board of California estimates costs of approximately $66,000 per year for enforcement-related workload (State Dentistry Fund).

- The Dental Hygiene Board of California indicates no fiscal impact since they already have a process in place that would comply with the bill's provisions.

Background:

Timely Access and Network Adequacy. Current law requires health plans and insurers to provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's/insured's condition consistent with good professional practice. Health plans and insurers must establish and maintain networks, policies, procedures, and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard. Health plans and insurers must ensure that their networks have adequate capacity and availability of licensed health care providers to offer enrollees/insureds appointments that meet specified timeframes. Current law also specifies required timely appointments that apply to health plans/insurers that provide dental services. Health plans and insurers must report annually to the DMHC/CDI on compliance with the timely access and network adequacy standards.

Assignment of Benefits. Patients enrolled in a Preferred Provider Organization (PPO) plan (including dental PPO plans) may seek services from non-contracted (out-of-network) providers. PPOs may allow for assignment of benefits to out-of-network providers, rather than reimbursing enrollees directly for covered services. Assignment of benefits refers to an arrangement whereby a patient requests that their health benefit

payments be made directly to a designated provider or facility, such as a physician or hospital. If a patient signs a written authorization, the out-of-network provider may seek to have the insurer 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 percent of the negotiated rate for contracted providers and the patient pays the remaining 20 percent of that negotiated rate. For non-contracted providers, the policy might only pay 60 percent 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.

Proposed Law: Specific provisions of the bill would:

- Define “assignment of benefits” to mean the transfer of reimbursement or other rights provided for under a health care service plan contract or health insurance policy to a treating provider for services or items rendered to an enrollee or insured.

- Require, upon written and dated consent of the enrollee/insured, a health plan/insurer covering dental services or a specialized health plan/policy covering dental services to pay the noncontracting dental provider directly for covered services rendered to the enrollee/insured in accordance with the benefit provided in the enrollee’s/insured’s contract/policy.

- Require, before accepting an assignment of benefits, a noncontracting dental provider to disclose all of the following to the enrollee/insured:

    - That the licensee is a noncontracting dental provider with respect to the enrollee’s/insured’s dental benefit plan/policy.

    - 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/policy.

    - An estimate of the planned treatment cost and an estimate of the enrollee’s/insured’s portion of that cost or a deposit that approximates cost share.

    - That the enrollee’s/insured’s plan/policy benefits may not apply to the treatment, and the noncontracting dental provider is not subject to contract requirements of the enrollee’s/insured’s dental benefit plan/policy.

    - That the enrollee/insured has the right to confirm their dental benefit or coverage information from their plan/insurer before beginning treatment.

    - 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 plan/insurer covering dental services or the specialized health plan/insurer covering dental services.

- Prohibit a noncontracting dental provider accepting assignment of benefits from charging the enrollee/insured prior to the plan/insurer payment more than an

estimate of the enrollee's/insured's cost sharing for the treatment or a deposit that approximates cost share.

- Specify that the provisions regarding assignment of benefits apply only to a health plan contract or health insurance policy covering out-of-network dental services or a specialized health plan contract or specialized health insurance policy covering out-of-network dental services, as specified.

- Specify that the provisions regarding assignment of benefits do not apply to Medi-Cal managed care plan contracts, including dental managed care contracts.

- Require dental plans/insurers, as defined, to certify, under penalty of perjury, that information and data submitted to DMHC/CDI related to timely access requirements is true and correct; require that this must include an attestation that, in determining and reporting on network adequacy, the plan/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; and authorize DMHC/CDI to conduct audits for compliance or in response to consumer complaints regarding network adequacy.

- Require that failure of a licensed dental provider to comply with the requirements related to the assignment of benefits provisions is considered unprofessional conduct under the state's Dental Practice Act.

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