THIRD READING

Bill No: AB 1629
Author: Haney (D), et al.
Amended: 6/25/26 in Senate
Vote: 21

SENATE HEALTH COMMITTEE: 9-2, 6/24/26
AYES: Weber Pierson, Caballero, Durazo, Gonzalez, Menjivar, Padilla, Pérez, Rubio, Smallwood-Cuevas
NOES: Valladares, Grove

SENATE BUS., PROF. & ECON. DEV. COMMITTEE: 8-2, 6/29/26
AYES: Wahab, Archuleta, Arreguín, Caballero, Grayson, Menjivar, Smallwood-Cuevas, Umberg
NOES: Niello, Strickland
NO VOTE RECORDED: Choi

SENATE APPROPRIATIONS COMMITTEE: 5-2, 8/13/26
AYES: Cervantes, Cabaldon, Grayson, Richardson, Wahab
NOES: Seyarto, Dahle

ASSEMBLY FLOOR: 61-0, 5/22/26 - See last page for vote

SUBJECT: Dental coverage

SOURCE: California Dental Association

DIGEST: This bill (1) 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. (2) Requires a plan or insurer to pay a noncontracting dental provider directly for covered services. (3) Makes it unprofessional conduct for a noncontracting dental provider to fail to inform an enrollee or insured of certain information and (4) prohibits a noncontracting dental

provider accepting assignment of benefits from charging the enrollee or insured prior to the plan payment, more than an estimate of the enrollee's or insured's cost-sharing for the treatment or a deposit that approximates cost-share.

ANALYSIS:

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. [Health & Safety Code (HSC) §1340, et seq., Insurance Code (INS) §106, et seq., and Welfare & Institutions Code (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 specified timeframes, unless the provider has determined and noted in the record that a longer waiting time is not detrimental. [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 specified requirements, such as within 72 hours for an urgent appointment and within 36 business days for a nonurgent appointment.

4) 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]

5) 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]

6) Establishes criteria for unprofessional conduct for licensees under the Dental Practices Act and the Dental Hygiene Board. [BPC §1680 and §1950.5]

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, upon written and dated consent, to also pay a noncontracting dental provider directly for covered

services rendered to an enrollee or insured in accordance with the contract or policy. 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 noncontracting dental provider to disclose, before accepting an assignment of benefits, all of the following:

   a) That the licensee is a noncontracting dental provider with respect to the 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.
   c) An estimate of the planned treatment cost and an estimate of the enrollee's or insured's portion of that cost or a deposit that approximates cost share.
   d) That the plan benefits may not apply to the treatment, and the noncontracting dental provider is not subject to contract requirements of the dental benefit plan.
   e) That the enrollee or insured has the right to confirm their dental benefit or coverage information from their plan or insurer 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 or insurance policy covering dental services or the specialized health care service plan or insurance policy covering dental services.

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

6) Requires a health care service plan covering dental services and a specialized health care service plan covering dental services to be considered a third-party payer, as specified.

7) Applies the assignment of benefits provisions to a health plan contract or health insurance policy covering out-of-network 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

8) Makes it unprofessional conduct for a person licensed under the Dental Practice Act to fail to provide an enrollee or insured with the disclosures described in 4) above, and to fail to comply with 5) above.

Comments

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.

Background

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. 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.

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 Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (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.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: Yes

According to the Senate Appropriations Committee, 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).

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.

SUPPORT: (Verified 8/14/26)

California Dental Association (source)

American Federation of State, County and Municipal Employees
Association of California State Supervisors
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
California Society of Pediatric Dentistry
California State Retirees
Dental Hygiene Board of California
San Francisco Marin Medical Society
SEIU California

OPPOSITION: (Verified 8/14/26)

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

ARGUMENTS IN 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. 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.

ARGUMENTS IN 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. 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.

ASSEMBLY FLOOR: 61-0, 5/22/26
AYES: Addis, Aguiar-Curry, Ahrens, Alanis, Alvarez, Ávila Farías, Bains, Bauer-Kahan, Bennett, Berman, Boerner, Bonta, Bryan, Calderon, Caloza, Carrillo, Connolly, DeMaio, Elhawary, Flora, Fong, Garcia, Gipson, Mark González, Haney, Harabedian, Hart, Irwin, Jackson, Kalra, Krell, Lee, Lowenthal,

McKinnor, Muratsuchi, Nguyen, Ortega, Pacheco, Papan, Patel, Pellerin, Petrie-Norris, Quirk-Silva, Ramos, Ransom, Michelle Rodriguez, Rogers, Blanca Rubio, Schiavo, Schultz, Sharp-Collins, Solache, Soria, Stefani, Valencia, Wallis, Ward, Wicks, Wilson, Zbur, Rivas

NO VOTE RECORDED: Arambula, Castillo, Chen, Davies, Dixon, Ellis, Gabriel, Gallagher, Jeff Gonzalez, Hadwick, Hoover, Johnson, Lackey, Macedo, Patterson, Celeste Rodriguez, Sanchez, Ta, Tangipa

Prepared by: Teri Boughton / HEALTH / (916) 651-4111
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