CONCURRENCE IN SENATE AMENDMENTS
AB 1629 (Haney)
As Amended August 20, 2026
Majority vote

SUMMARY

Requires a health care service plan (health plan) or health insurer to pay a non-contracting dental provider *or registered dental hygienist in alternative practice* directly for covered services if the non-contracting provider submits a written assignment of benefits (AOB) form signed by the enrollee. Requires a non-contracting provider to disclose specified information on out-of-pocket costs to the patient *and obtain signed and dated consent to an AOB.*

Senate Amendments

1) Strike language requiring Department of Managed Health Care (DMHC) and California Department of Insurance (CDI) to collect and report information on dental provider network adequacy. Instead require a dental plan or insurer to certify, under penalty of perjury, that information and data submitted to DMHC and CDI is true and correct. Require that this includes an attestation that in determining and reporting on network adequacy, the plan or 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. Authorize DMHC and CDI to adopt additional standards and audit plans for compliance.

2) Strike provider to patient disclosure requirements from the Insurance Code and add them to the Business and Professions code.

3) Expand consumer protections and clarify provider obligations regarding AOB, including prohibiting a non-contracting provider from charging the patient more than the estimate of their cost-sharing for treatment prior to payment from the plan or insurer.

4) Add intent language on holding dental plans accountable for meeting network adequacy standards while staying within the authority of the state's regulatory authority.

COMMENTS

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 and CDI. The Patient Protection and Affordable Care Act (ACA) 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.

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.

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:

1) *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:

    a) Urgent care *within 72 hours;*

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

    c) Preventive dental care *within 40 business days*.

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

a) Urgent care without prior authorization: *within 48 hours*

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

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

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

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

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

2) *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.

According to the Author
Every month, millions of Californians pay their monthly dental insurance bill but never get the care they are entitled to. The author continues that 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.

Arguments in 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.

Arguments in Opposition
Delta Dental of California (Delta Dental) is opposed to this bill, stating that it fails to address any documented problem or issue in the California dental benefit marketplace. Delta Dental continues that mandatory AOB fundamentally alters the structure that supports dental networks and helps keep dental care affordable. Delta Dental argues that dental networks function through a clear and deliberate exchange. Participating dentists agree to accept negotiated fees, comply with contractual standards, and provide defined consumer protections; in return, they receive direct reimbursement, predictable payment, and access to a broader patient base. Delta Dental continues that the ability to receive direct reimbursement from a dental plan is a primary reason dentists elect to participate in networks and agree to discounted fee schedules that lower costs for patients. Delta Dental states that in states that mandate AOB, dentist participation in PPO provider networks is approximately 7% lower than in states without such mandates. 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 our enrollees would increase by approximately $250 million to $740 million annually. Delta Dental further argues that this bill does not go far enough to ensure meaningful consumer protection. Delta Dental continues that this bill does not provide meaningful recourse when disclosures are incomplete, unclear, or not provided. In such instances, enrollees may be exposed to unexpected and potentially significant out-of-pocket costs without proper advance notice or an opportunity to make informed decisions about their care.

FISCAL COMMENTS

According to the Senate Appropriations Committee:

1) *The 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).*

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

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

4) *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.*

VOTES:

ASM HEALTH: 12-0-4
YES: Bonta, Addis, Aguiar-Curry, Ahrens, Caloza, Carrillo, Mark González, Patel, Rogers, Schiavo, Sharp-Collins, Stefani
ABS, ABST OR NV: Chen, Johnson, Patterson, Sanchez

ASM APPROPRIATIONS: 11-0-4
YES: Wicks, Aguiar-Curry, Calderon, Caloza, Fong, Mark González, Krell, Pacheco, Pellerin, Sharp-Collins, Solache
ABS, ABST OR NV: Hoover, Dixon, Ta, Tangipa

ASSEMBLY FLOOR: 61-0-19
YES: 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
ABS, ABST OR NV: Arambula, Castillo, Chen, Davies, Dixon, Ellis, Gabriel, Gallagher, Jeff Gonzalez, Hadwick, Hoover, Johnson, Lackey, Macedo, Patterson, Celeste Rodriguez, Sanchez, Ta, Tangipa

UPDATED

VERSION: June 25, 2026

CONSULTANT: Riana King / HEALTH / (916) 319-2097 FN: 0004132