SENATE JUDICIARY COMMITTEE
Senator Thomas Umberg, Chair
2025-2026 Regular Session

AB 1770 (Garcia)
Version: April 13, 2026
Hearing Date: June 23, 2026
Fiscal: Yes
Urgency: No
AM

SUBJECT

Arbitration: health care service plans

DIGEST

This bill provides that the Attorney Geneal (AG) has oversight over, and may require reports from, health care service plans to ensure that such plans that include a term requiring the parties to submit to binding arbitration to settle disputes comply with certain requirements under existing law. The bill also requires, notwithstanding any other law, that an arbitration claim initiated pursuant to a health care service plan is to be conducted pursuant to the California Arbitration Act.

EXECUTIVE SUMMARY

Arbitration is an alternative method for resolving legal disputes. Instead of going through the formal, public court process, the parties to the dispute submit their evidence and legal arguments to a private arbitrator (or a panel of arbitrators) who decides the case. The arbitration decision is generally not appealable through the courts. The California Arbitration Act (CAA0 generally governs arbitration in the state; however, more specific statutes exist to govern arbitration claims arising under health care service plans, including disclosure requirements and the selection of an arbitrator. While proponents of arbitration argue it has the potential to streamline dispute resolution, consumer advocates argue it can result in rulings that leave consumers with little recourse and a sense of injustice as they were denied a full court hearing. This bill seeks to enhance transparency and oversight over arbitration claims arising under health care service plans by placing oversight with the AG.

This bill is sponsored by the Patient Equity Coalition and Praxis Project. It is supported by APA Family Support Services, Asian Pacific Partners for Empowerment, Advocacy and Leadership (APPEAL), Black Women for Wellness, the California Federation of Teachers, Healthy Black Families, Khmer Girls in Action, the Multicultural Institute, the Prevention Institute, and 1 individual. No timely opposition was received by the

Committee. Should this bill pass this Committee, it will next be referred to the Senate Health Committee.

PROPOSED CHANGES TO THE LAW

Existing federal law:

1) Provides, pursuant to the Federal Arbitration Act (FAA), that a written provision in any maritime transaction or a contract evidencing a transaction involving commerce to settle by arbitration a controversy thereafter arising out of such contract or transaction, or the refusal to perform the whole or any part thereof, or an agreement in writing to submit to arbitration an existing controversy arising out of such a contract, transaction, or refusal, shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract. (9 U.S.C. § 2.)

Existing state law:

1) Governs arbitrations in California pursuant to the California Arbitration Act (CAA), including the enforcement of arbitration agreements, rules for neutral arbitrators, the conduct of arbitration proceedings, and the enforcement of arbitration awards. (Code Civ. Proc. §§ 1280 et seq.)

2) Provides that a written agreement to submit to arbitration an existing controversy or a controversy thereafter arising is valid, enforceable and irrevocable, save upon such grounds as exist for the revocation of any contract. (Code Civ. Proc. § 1281.)

3) Requires the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene), and the Department of Health Care Services (DHCS) to administer the Medi-Cal program. (Health & Safe. Code Q§1340, et seq.[1]; Welf. & Inst. Code §§ 14000, et. seq.)

4) Provides that any health care service plan that includes terms that require binding arbitration to settle disputes and that restrict, or provide for a waiver of, the right to a jury trial shall include, in clear and understandable language, a disclosure that meets all of the following conditions:
    a) A disclosure that must clearly state whether the plan uses binding arbitration to settle disputes, including specifically whether the plan uses binding arbitration to settle claims of medical malpractice.
    b) The disclosure must appear as a separate article in the agreement issued to the employer group or individual subscriber and is required to be

[1] All further references are the Health and Safety Code unless specified otherwise.

prominently displayed on the enrollment form signed by each subscriber or enrollee.

c) The disclosure is required to clearly state whether the subscriber or enrollee is waiving their right to a jury trial for medical malpractice, other disputes relating to the delivery of service under the plan, or both, and is required to be substantially expressed in the wording provided in subdivision (a) of Section 1295 of the Code of Civil Procedure.
d) In any contract or enrollment agreement for a health care service plan, the required disclosure is to be displayed immediately before the signature line provided for the representative of the group contracting with a health care service plan and immediately before the signature line provided for the individual enrolling in the health care service plan.

5) Provides that any health care service plan that includes a term that requires the parties to submit to binding arbitration for cases or disputes for which the total amount of damages claimed is $200,000 or less shall provide for selection by the parties of a single neutral arbitrator who shall have no jurisdiction to award more than $200,000.
   a) This provision shall not be subject to waiver, except that nothing is to prevent the parties to an arbitration from agreeing in writing, after a case or dispute has arisen and a request for arbitration has been submitted, to use a tripartite arbitration panel that includes two party-appointed arbitrators or a panel of three neutral arbitrators, or another multiple arbitrator system mutually agreeable to the parties.
      i. The agreement shall clearly indicate, in boldface type, that "A case or dispute subject to binding arbitration has arisen between the parties and we mutually agree to waive the requirement that cases or disputes for which the total amount of damages claimed is $200,000 or less be adjudicated by a single neutral arbitrator."
      ii. If the parties agree to waive the requirement to use a single neutral arbitrator, the enrollee or subscriber shall have three business days to rescind the agreement.
      iii. If the agreement is also signed by counsel of the enrollee or subscriber, the agreement shall be immediately binding and may not be rescinded.
      iv. If the parties are unable to agree on the selection of a neutral arbitrator, and the plan does not use a professional dispute resolution organization independent of the plan that has a procedure for a rapid selection or default appointment of a neutral

arbitrator, the method provided in Section 1281.6 of the Code of Civil Procedure may be utilized.[2] (Health & Saf. Code § 1373.19.)

6) Provides that if a health care service plan uses arbitration to settle disputes with enrollees or subscribers, and does not use a professional dispute resolution organization independent of the plan that has a procedure for a rapid selection, or default appointment, of neutral arbitrators, the following requirements shall be met by the plan with respect to the arbitration of the disputes and shall not be subject to waiver:
    a) If the party seeking arbitration and the plan against which arbitration is sought, in cases or disputes requiring a single neutral arbitrator, are unable to select a neutral arbitrator within 30 days after service of a written demand requesting the designation, it shall be conclusively presumed that the agreed method of selection has failed and the method provided in Section 1281.6 of the Code of Civil Procedure may be utilized.
    b) In cases or disputes in which the parties have agreed to use a tripartite arbitration panel consisting of two party arbitrators and one neutral arbitrator, and the party arbitrators are unable to agree on the designation of a neutral arbitrator within 30 days after service of a written demand requesting the designation, it shall be conclusively presumed that the agreed method of selection has failed and the method provided in Section 1281.6 of the Code of Civil Procedure may be utilized. (Health & Saf. Code § 1373.20(a).)

7) Provides that, if a court reviewing a petition filed under 5) or 6), above, finds that a party has engaged in dilatory conduct intended to cause a delay in proceeding under the arbitration agreement, the court, by order, may award reasonable costs, including attorney fees, incurred in connection with the filing of the petition.
    a) If a plan uses arbitration to settle disputes with enrollees or subscribers, the following requirements shall be met with respect to extreme hardship cases:
        i. The plan contract shall contain a provision for the assumption of all or a portion of an enrollee's or subscriber's share of the fees and expenses of the neutral arbitrator in cases of extreme hardship.
        ii. The plan shall disclose this provision to subscribers in any evidence of coverage issued or amended after August 1, 1997.
        iii. The plan shall provide enrollees, upon request, with an application for relief under this subdivision, or information on how to obtain an application from the professional dispute resolution organization that will administer the arbitration process. If the plan

[2] Section 1281.6 of the Code of Civil Procedure allows a court to appoint an arbitrator, on petition of a party, in the absence of an agreed method, or if the agreed method fails or for any reason cannot be followed.

uses a professional dispute resolution organization independent of the plan, the provision for assumption of the arbitration fees in cases of extreme hardship shall be established and administered by the dispute resolution organization.

b) Approval or denial of the application shall be determined by either:
   i. a professional dispute resolution organization independent of the plan if the plan uses a professional dispute resolution organization; or
   ii. a neutral arbitrator who is not assigned to hear the underlying dispute, who has been selected pursuant to 6),a), above, and whose fees and expenses are paid for by the plan. (Health & Saf. Code § 1373.20(b).)

8) Provides that, if a health care service plan uses arbitration to settle disputes with enrollees or subscribers, it shall require that an arbitration award be accompanied by a written decision to the parties that indicates the prevailing party, the amount of any award and other relevant terms of the award, and the reasons for the award rendered.
   a) A copy of any modified written decision, including the amount of the award and other relevant terms of the award, the reasons for the award rendered, the name of the arbitrator or arbitrators, but excluding the names of the enrollee, the plan, witnesses, attorneys, providers, health plan employees, and health facilities, shall be provided to DMHC on a quarterly basis.
   b) DMHC shall make these modified decisions available to the public upon request.
   c) DMHC is not precluded from requesting and securing from any plan copies of complete arbitration decisions for the purposes of administering Knox-Keene.
   d) These provisions do not preclude DMHC, or any plan or person, from disclosing information contained in an arbitration decision if the disclosure is otherwise permitted by law. (Health & Saf. Code § 1373.21.)

This bill:

1) Provides that the AG has oversight over, and may require reports from, health care service plans to ensure that such plans that include a term requiring the parties to submit to binding arbitration to settle disputes comply with the requirements set forth in Section 1363.1 and Sections 1373.19 to 1373.21, inclusive, of the Health and Safety Code.

2) Requires, notwithstanding any other law, that an arbitration claim initiated pursuant to a health care service plan is to be conducted pursuant to the CAA.

COMMENTS

1. Author statement

The author writes:

> This bill is all about restoring faith in the arbitration process; Californians deserve a just and equitable path towards resolving health care claims. The current structure creates an incentive for a repeat- player bias for the plans versus the individual enrollee. Cost, unfamiliarity with the system and lack of transparency mean there is no oversight to ensure that the California Arbitration Act is being complied with in fact or in spirit. AB 1770 aims to give the Department of Justice clear oversight authority to mitigate against structural problems.

2. Arbitration

   a. Background

Arbitration is an alternative method for resolving legal disputes. Instead of going through the formal, public court process, the parties to the dispute submit their evidence and legal arguments to a private arbitrator (or a panel of arbitrators) who decides the case. Generally, the arbitration decision is not appealable. Generally, supporters of arbitration assert that private arbitration provides a cheaper, faster, more efficient form of dispute resolution than the overburdened courts, because they are able to limit discovery, set their own rules for presenting evidence, schedule proceedings at their own convenience, and select the third party who will decide their cases. However, critics of private arbitration contend that it is an unregulated industry, which is often costly and unreceptive to consumers and employees. Consumer advocates view mandatory arbitration as putting consumers and employees on an uneven playing field that creates an inclination by arbitrators to decide cases in favor of businesses. They further view arbitration as an expensive process which also puts consumers at a disadvantage by imposing procedural limitations on their ability to pursue their legal claims.

On March 1, 2016, the Senate Judiciary Committee held an informational hearing on the topic of private arbitration agreements, entitled “The Federal Arbitration Act (FAA), the U.S. Supreme Court, and the Impact of Mandatory Arbitration on California Consumers and Employees.” In that hearing, many issues facing consumers and employees who are subject to arbitration clauses contained in standardized, take-it-or-leave-it, or “adhesive” contracts were brought to light. That hearing also brought to light the various difficulties facing the state in addressing some of the underlying, fundamental harms faced by consumers and employees as a result of federal preemption and U.S. Supreme Court precedent interpreting the FAA.

b. Federal Preemption and the FAA

The FAA was enacted by the U. S. Congress in 1925 in response to widespread judicial hostility to arbitration agreements. Section 2 of the FAA generally provides that a written provision in any contract evidencing a transaction involving commerce to settle by arbitration a controversy thereafter arising out of such contract or transaction shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract. (*See* 9 U.S.C. § 2; similar language is contained within the CAA at Code Civ. Proc. § 1281.) In assessing whether a state law is preempted by the FAA, three key aspects of the law surrounding arbitration and preemption are especially relevant. First, the federal courts have ruled that the FAA was intended to promote arbitration.[3] Second, state laws or rules that interfere with the enforcement of arbitration agreements are preempted, except on such grounds as exist at law or in equity for the revocation of any contract.[4] Third, state laws that explicitly or covertly discriminate against arbitration agreements as compared to other contracts are also preempted.[5] Generally, states have been allowed to regulate the procedures governing arbitration agreements in their state under the FAA.

c. The CAA

The CAA governs arbitrations in the state. It provides for the enforcement of arbitration agreements, and provides rules regarding the conduct of arbitration agreements, including evidentiary issues, and how an arbitration award is to be enforced. Under the CAA, a party to arbitration is entitled to be represented by an attorney and have a certified shorthand reporter transcribe the proceeding. (Civ. Code §§ 1282.4(a) & 1282.5, respectively.) Additionally, a neutral arbitrator is authorized to administer oaths, and limited grounds for appeals of certain actions are granted. (Civ. Code §§ 1282.8 & 1294, respectively.)

d. Arbitration under Knox-Keene

Knox-Keene provides certain requirements for arbitrations arising out of a health care service plan. These provisions impose notice requirements on health care service plans that include binding arbitration clauses, and provide standards and requirements for the selection of a neutral arbitrator. In addition, an arbitration decision is to be in writing and must include: 1) the prevailing party; 2) any award and terms of the award; and 3) the reasons for the award. Existing law requires that information about arbitration awards be provided to DMHC on a quarterly basis, and DMHC is required to make modified decisions available to the public upon request. DMHC is not precluded from requesting and securing from any health care service plan copies of complete arbitration decisions for the purposes of administering Knox-Keene. These

[3] *Epic Sys. Corp. v. Lewis* (2018) 584 U.S. 497, at 505.
[4] 9 U.S.C. Sec. 2; *AT&T Mobility LLC v. Concepcion* (2011) 563 U.S. 333, 339.
[5] *Epic Sys. Corp.*, 584 U.S. at 546-548.

provisions do not preclude DMHC, or any plan or person, from disclosing information contained in an arbitration decision if the disclosure is otherwise permitted by law.

3. This bill seeks to provide more transparency and regulation over arbitration agreements under Knox-Keene

This bill is inspired by the experience of Stephen Martinez and Lindalee Iveson attempting to navigate the arbitration process with their HMO healthcare. In op-ed for CalMatters, Stephen Martinez wrote of his and his wife's experience stating:[6]

> In 2010, Lindalee noticed a large lump in her left breast. Her HMO denied her an appointment with her longstanding OBGYN and sent her to a substandard clinic instead.
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> Years of pain and suffering, multiple surgeries and a diminished quality of life resulted.
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> We wanted to exercise our constitutional right to seek justice in court, but we learned big healthcare corporations force patients to sign away such rights. "OK," we thought, "arbitration must be somewhat court-like and fair and efficient." So we began that process.
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> It took three years. The arbitrator allowed endless delays, games with witnesses and evidence destruction. Several experts testified that the HMO's mistakes — multiple misdiagnoses, divergence from procedures, denied follow-up examinations — had caused Lindalee's issues.
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> Notably, an unsupervised physician's assistant had dismissed a breast lump in Lindalee, a 55-year-old post-menopausal woman. Despite a high probability it was cancer, the physician's assistant prescribed warm compresses and a sports bra and advised Lindalee to avoid chocolate.
>
> Arbitration was almost as bad as the cancer. An exhausting deposition brought Lindalee to tears. The HMO's attorney then grilled her for five hours at the arbitration. The attorney argued Lindalee was entirely to blame for her breast cancer spreading, which struck me as victim blaming.
>
> The verdict was shocking. "The Arbitrator finds that [the HMO's] treatment … was within the standard of care … Claimants are to take nothing."

[6] *She spent six of her last years in arbitration with her HMO. Her husband's still fighting the system*, CalMatters, (Feb. 26, 2026), available at https://calmatters.org/commentary/2026/02/hmo-arbitration-battle-bias-california/.

> This was despite two HMO surgeons, with 60 years of combined breast cancer expertise, testifying that the HMO had failed to follow its standard of care.
>
> Surely our experience of HMO error, yet head-scratching arbitration outcome must be an outlier, we thought.
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> Lindalee had just finished the breast cancer ordeal when she developed a blockage in her intestine. It was clearly captured in a CT scan. For two years, the HMO failed to act on that report's recommendations.
>
> After finally getting a gastroenterology referral, Lindalee was seen by an unsupervised nurse practitioner who failed to diagnose the issue. When Lindalee finally got to a GI doctor, he told her plainly, "This could kill you." She underwent emergency surgery.
>
> Faced with another HMO error, we proceeded with arbitration again. We had chalked up our first experience as a fluke. But just like the first case, this process also took three years. […]

According to the author and sponsor, this bill will improve confidence and transparency in the arbitration process for health care service plans. The bill requires the AG to oversee compliance with Knox-Keene and the CAA for health care service plans by authorizing the AG to require reports from health care service plans regarding arbitration under Knox-Keene to ensure that health care service plans are complying with Knox-Keene and the CAA. The bill also reiterates that the CAA also applies to claims to arbitrate under Knox-Keene.

4. <u>Stakeholder statements</u>

The Praxis Project, one of the sponsors of the bill, writes in support stating:

> Health care is already expensive and difficult to navigate, and patients often face complex barriers when trying to obtain timely and appropriate care. AB 1770 is a critical step forward because it strengthens neutrality, transparency, and oversight in the arbitration process and begins to restore fairness and public confidence for consumers and families. The bill would require qualified arbitrators with expertise in medical malpractice, remove health plans from arbitrator selection, and improve transparency, oversight, and accountability in arbitration proceedings. These reforms are essential to ensure that Californians have a fair and credible path to justice when seeking accountability for medical harm.

Kaiser Permanente writes in concern with bill stating that subdivision (a) of the bill is unnecessary, duplicative, and likely to create confusion regarding enforcement authority and ask that it be removed.

SUPPORT

Patient Equity Coalition (sponsor)
Praxis Project (sponsor)
APA Family Support Services
Asian Pacific Partners for Empowerment, Advocacy and Leadership (APPEAL)
Black Women for Wellness
California Federation of Teachers
Healthy Black Families
Khmer Girls in Action
Multicultural Institute
Prevention Institute
1 individual

OPPOSITION

None received

RELATED LEGISLATION

Pending Legislation: None known.

Prior Legislation: None known.

PRIOR VOTES

Assembly Floor (Ayes 60, Noes 15)
Assembly Appropriations Committee (Ayes 11, Noes 4)
Assembly Judiciary Committee (Ayes 10, Noes 2)
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