# SENATE COMMITTEE ON HEALTH
**Senator Akilah Weber Pierson, Chair**

**BILL NO:** AB 1770
**AUTHOR:** Garcia
**VERSION:** April 13, 2026
**HEARING DATE:** July 1, 2026
**CONSULTANT:** Teri Boughton

**SUBJECT:** Arbitration: health care service plans

**SUMMARY:** Gives the Attorney General oversight over, and authority to request reports from health plans to ensure that health plans requiring binding arbitration to settle disputes comply with requirements in the Knox-Keene Health Care Service Plan Act of 1975, as specified, and requires an arbitration claim initiated pursuant to a health plan to be conducted pursuant the California Arbitration Act and arbitration of medical malpractice provisions, as specified in the California Code of Civil Procedure.

**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) [HSC §1340, et seq.]

2) Requires any health 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 to include, in clear and understandable language, a disclosure that meets all of the following conditions:
   a) Clearly states whether the health plan uses binding arbitration to settle disputes, including specifically whether the plan uses binding arbitration to settle claims of medical malpractice;
   b) Appears as a separate article in the agreement issued to the employer group or individual subscriber and to be prominently displayed on the enrollment form signed by each subscriber or enrollee;
   c) Clearly states whether the subscriber or enrollee is waiving his or her right to a jury trial for medical malpractice, other disputes relating to the delivery of service under the plan, or both, and to be substantially expressed in the wording provided in a specified section of the Code of Civil Procedure; and,
   d) Is displayed immediately before the signature line provided for the representative of the group contracting with a health plan and immediately before the signature line provided for the individual enrolling in the health plan in any contract or enrollment agreement for a health plan. [HSC §1363.1]

3) Establishes a process for selection of an arbitrator for disputes where the total amount of damages claimed is $200,000 or less, and allows for tripartite arbitration, as specified, when a health plan requires binding arbitration to settle disputes. [HSC §1373.19]

4) Establishes, if a plan uses arbitration to settle disputes, requirements for when a plan does not use an independent professional dispute resolution organization that has a procedure for rapid selection or default appointment of neutral arbitrators. [HSC §1373.20]

5) Requires a health plan, if it uses arbitration to settle disputes with enrollees or subscribers, to 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. [HSC 1373.21]

6) Requires 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(s), but not the names of enrollees, and others, to be provided to DMHC on a quarterly basis. Requires DMHC to make these modified decisions available upon request. This does not preclude DMHC from requesting and securing from any plan copies of complete arbitration decisions. Prohibits DMHC from releasing, in response to a request for information, identifying information of a person or entity whose name has been or should have been removed. [HSC §1373.21]

7) Establishes the California Arbitration Act (CAA) which governs arbitrations in California, including enforcement of arbitration agreements, rules for neutral arbitrators, the conduct of arbitration proceedings, and the enforcement of arbitration awards [CCP §1280, et seq.]

8) Establishes a process for disclosures related to contracts for medical services which require arbitration of any dispute as to professional negligence. [CCP §1295]

**This bill:**

1) Gives the Attorney General (AG) oversight over, and authority to request reports from health plans to ensure health plans that include a term requiring the parties to submit to binding arbitration to settle disputes comply with requirements in the Knox-Keene Act.

2) Requires, notwithstanding any other law, an arbitration claim initiated pursuant to a health plan to be conducted pursuant to the CAA and arbitration of medical malpractice provisions specified in the California Code of Civil Procedure.

**FISCAL EFFECT:** According to the Assembly Appropriations Committee, ongoing costs to the Department of Justice (DOJ) to oversee compliance by health care service plans with specified provisions regulating the use of binding arbitration to settle disputes (Unfair Competition Law, General Fund). The Healthcare Rights and Access Section, within the Public Rights Division of DOJ anticipates an increase in workload investigating and litigating the mandate of the bill. The bill's oversight grant is open-ended: it does not specify the frequency, scope, or form of oversight activities, or the content, frequency, or format of reports the AG may require. DOJ workload will depend on the intensity with which the AG exercises this discretionary authority. To address the additional anticipated workload, DOJ reports needing four deputy attorneys general, a legal analyst, and three legal secretaries. DOJ estimate workload costs of $1.1 million in fiscal year (FY) 2026-27 and $2 million for FY 2027-2028 and ongoing.

**PRIOR VOTES:**

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|---|---|
| Senate Judiciary Committee: | 11 - 2 |
| Assembly Floor: | 60 - 15 |
| Assembly Appropriations Committee: | 11 - 4 |
| Assembly Judiciary Committee: | 10 - 2 |

**COMMENTS:**

1) *Author's statement.* According to the author, 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 CAA is being complied with in fact or in spirit. This bill aims to give the Department of Justice clear oversight authority to mitigate against structural problems.

2) *Background.* This bill is inspired by the experience of one of this bill's cosponsors who was involved in two separate arbitrations on behalf of care provided to his wife through an HMO. A February 2026 *CalMatters* op-ed describes their experience, indicating one arbitration took three years, with delays and evidence destruction. Ultimately a decision that the care was within the standard of care, despite testimony to the contrary from expert witnesses, was issued. A second arbitration also took three years and was described "as more of a circus than the first."

3) *DMHC Arbitration Information.* DMHC-licensed health plans that use arbitration to settle disputes with members must file a copy of written arbitration decisions within 30 days of the decision with DMHC. The filed copy must include the amount of the award, if any, the reasons for the award/decision, and the names of the arbitrators. By law, the names of the health plan, the health plan member, witnesses, attorneys, provider, health plan employees, and health plan facilities are deleted from the copy filed with the DMHC. Health plans must file copies of these redacted arbitration decisions with the DMHC quarterly. Arbitration decisions are available for view on the DMHC website. There appear not to be any statistics by plan or tally of arbitration outcomes available.

4) *Double referral.* This bill was heard in the Senate Judiciary Committee on June 23, 2026, and passed on a vote of 11-2.

5) *Support.* The Patient Equity Coalition, a cosponsor, indicates that federal law has eroded meaningful guardrails around arbitration, and health coverage patients who are enrolled in private plans are locked into binding arbitration with limited transparency, minimal oversight, and few meaningful avenues to challenge procedures that do not comply with CAA. The Patient Equity Coalition believes the system is structurally biased, because arbitration companies are financially dependent on repeat business from health plans, they face little meaningful review, and serious errors or misconduct often goes unchecked. The Patient Equity Coalition believes placing oversight of health plan compliance with CAA with the DOJ and empowering the AG to require reports to ensure compliance will target financial bias and unethical practices and help effectuate greater neutrality in the arbitration process. Another cosponsor, the Praxis Project, believes this bill strengthens protections for patients and families seeking accountability after medical harm. They write that health care is already expensive and difficult to navigate, and this bill 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.

6) *Concerns.* Kaiser Permanente believes Section 12529.9(a) is unnecessary, duplicative, and likely to create confusion regarding enforcement authority, because it describes the AG as having oversight of health plans' compliance with provisions of the Knox-Keene Act, and the AG already has independent authority to enforce exist law where appropriate. Kaiser requests this provision be removed.

7) *Amendments.* To make sure this bill, if enacted, cannot be interpreted as a limitation on either DMHC's or the AG's current authority, the Committee may wish to adopt the amendments described below.

(c) The authority of the Attorney General to act based on the oversight granted under Government Code Section 12529.9(a), including investigating and prosecuting any violations of state unfair competition or any other state law, is not narrowed, abrogated, or otherwise altered by this Act or any other law.
(d) The authority of the Department of Managed Health Care to act under Sections 1340 to 1399.874, inclusive of the Health and Safety Code, including Section 1363.1 and Sections 1373.19 to 1373.21, inclusive, of the Health and Safety Code, is not narrowed, abrogated, or otherwise altered by this Act.

**SUPPORT AND OPPOSITION:**

**Support:** Patient Equity Coalition (co-sponsor)
The Praxis Project (co-sponsor)
AARP
Alameda County Democratic Party
APA Family Support Services
Asian Pacific Partners for Empowerment, Advocacy and Leadership
Black Women for Wellness
California Advocates for Nursing Home Reform
California Alliance of Child and Family Services
California Long Term Care Ombudsman Association
California Low-Income Consumer Coalition
California Senior Legislature
California Women's Law Center
Consumer Attorneys of California
Consumer Watchdog
Courage California
Friends Committee on Legislation of California
Healthy Black Families
Khmer Girls in Action
Multicultural Institute
Prevention Institute
An Individual

**Oppose:** None received

**-- END --**