Date of Hearing: April 7, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2431 (Patel) – As Introduced February 20, 2026

**SUBJECT**: Downcoding medical claims.

**SUMMARY**: Prohibits a health plan and health insurer from using an automated process, system, or tool to downcode a claim. Specifically, **this bill**:

1) Prohibits a health plan or health insurer from using an automated process, system or tool to downcode a claim.

2) Requires downcoding decisions to solely be made by a licensed physician or licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services included in the claim and who has performed a documented review of the clinical information supporting the billed service, which is relevant to determining the propriety of the billed code pursuant to applicable national coding guidelines.

3) Prohibits a health plan or health insurer from downcoding a claim based solely on information reported on the claim form, including, but not limited to, the reported diagnosis or procedure codes.

4) Requires, if a claim is downcoded, the health plan or health insurer to notify and provide the billing provider with an accurate and clear written explanation of the specific reasons for the action taken, to clearly indicate that the claim has been downcoded, and provide all of the following:

    a) The specific reason for the downcoding, including all of the following in sufficient detail to enable a billing provider to determine what additional documentation or claim corrections would be necessary for the claim to be reimbursed:

        i) Reference to the coding criteria used to justify the downcoding;

        ii) The specific criterion deemed to be not met; and,

        iii) A description of the specific deficiency at issue in the claim.

    b) The original and revised service codes and payment amounts; and,

    c) A notice of the provider dispute resolution mechanism described in 5) below.

5) Requires, if a claim is downcoded, the health plan or health insurer to provide the billing provider with a clear and accessible process for disputing downcoded claims, including all of the following:

    a) A written notice detailing how to initiate a provider dispute;

    b) Contact information for the individual managing the provider dispute;

c) The timeline for submission of a provider dispute that is no less than 365 days from the plan or insurer's or the plan or insurer's capitated provider's most recent action or, in the case of inaction, that is less than 365 days after the most recent time for contesting or denying claims has expired; and,

d) The timeline, not to exceed 45 working days after receipt of a provider dispute or amended provider dispute, for adjudicating the provider dispute and issuing a written determination to the provider stating the pertinent facts and explaining the reasons for the determination.

6) Requires billing providers to have the right to appeal batches of similar claims involving substantially similar downcoding issues, without restriction.

7) Requires a health plan or health insurer to resolve provider disputes for downcoded claims in accordance with any other applicable state or federal law.

8) Prohibits a health plan or insurer from using downcoding practices in a targeted or discriminatory manner against physicians or other health care providers who routinely treat patients with high acuity, complex, or chronic conditions.

9) Requires a pattern or practice of discriminatory downcoding identified by the Department of Managed Health Care (DMHC) or California Department of Insurance (CDI) to be subject to enforcement actions, including fines, restitution, or suspension of licensure under this chapter.

10) Permits the director of the DMHC and the Insurance Commissioner to enforce violations of this bill. Upon determining a violation, requires DMHC or CDI to:

a) Impose monetary penalties as permitted under existing law;

b) Order the insurer to reprocess improperly downcoded claims with interest, as applicable;

c) Order the insurer, for a period of three years from the date of DMHC or CDI's determination, or for a shorter period prescribed by the commissioner, to pay complete and accurate claims from the provider within a shorter period of time than that required by existing law, as applicable; and,

d) Make a claim for costs incurred by DMHC or CDI in an administrative or judicial action, including investigative expenses and the cost to monitor compliance by the insurer.

11) Makes legislative findings and declarations on the impact of medical claim downcoding.

**EXISTING LAW**:

1) Establishes DMHC to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 and CDI to regulate health insurance under the Insurance Code. [Health and Safety Code (HSC) § 1340, *et seq*., Insurance Code (INS) § 106, *et seq*.]

2) Requires that health plan and insurer contracts with providers, and others, are fair, reasonable, and consistent with the objectives of existing law. Requires all contracts with providers to contain provisions requiring a fast, fair, and cost-effective dispute resolution

mechanism under which providers may submit disputes, and requiring the plan or insurer to inform its providers of procedures for processing and resolving disputes, as specified. [HSC § 1367 & INS § 10123.137]

3) Requires a health plan or insurer to annually report to DMHC or CDI regarding its dispute resolution mechanism, including the information on the number of providers who utilized the mechanism and a summary of the disposition of those disputes. [HSC § 1367 & INS § 10123.137]

4) Requires DMHC and permits CDI to adopt regulations that ensure plans and insurers have adopted a dispute resolution mechanism. Requires DMHC regulations to require that any dispute resolution mechanism is fair, fast, and cost-effective for contracting and non-contracting providers and define the term "complete and accurate claim, including attachments and supplemental information or documentation." [HSC § 1371.38 & INS § 10123.147

5) Requires a health plan or health insurer that utilizes an artificial intelligence (AI), algorithm, or other software tool for the purpose of utilization review or utilization management, as specified, to ensure compliance with specified requirements, including that the AI, algorithm, or other software tool bases determination on specified information and is applied fairly and equitably. [HSC § 1367.01 & INS § 10123.135]

6) Prohibits a health plan from engaging in an unfair payment pattern. Permits DMHC to investigate a health plan to determine if it has engaged in an unfair payment pattern, as defined. Permits DMHC to impose penalties on a plan that has engaged in an unfair payment pattern. [HSC § 1371.37]

**FISCAL EFFECT**: Unknown. This bill has not been analyzed by a fiscal committee.

**COMMENTS**:

1) **PURPOSE OF THIS BILL.** According to the author, California already faces a serious shortage of primary care physicians. The author states that algorithmic downcoding accelerates that crisis by making independent practice financially unsustainable. The author argues that this bill closes a clear gap: before a health plan reduces payment, a clinician must review the record and justify the change. California's physicians are dedicated to providing the highest quality of care to their patients, but automatic downcoding algorithms are making this increasingly difficult. The author states that this bill ensures that any reduction in payment is grounded in an actual clinical review and not software algorithms. The author concludes that when we protect physicians' ability to practice sustainably, we protect patients' access to the care they deserve.

2) **BACKGROUND.** The cost of health care is steadily increasing in California. Millions can't afford the care they need. According to the California Health Care Foundation (CHCF), more than half of all Californians skip or delay getting care because it costs too much. In CHCF's publication, "The 25% Problem: Why Health Care Is So Expensive (And What We Can Do About It)," they detail that 25 cents of every dollar in our health care system doesn't provide any value or care to patients. In 2020, this added up to as much as $73 billion dollars in excess health care spending. The top three culprits of the 25% problem are: administrative complexity, unfair pricing and too few choices, and not enough prevention in health care.

CHCF argues that the solution to the state's health care affordability crisis isn't to slash health care spending across the board. Instead, they urge the state to focus on cutting the 25% that doesn't provide any value for patients.

a) **Administrative complexity.** Administrative tasks, such as claims and billing, are one of the leading drivers of the 25% problem. Providing health care requires administrative work. Doctors and hospitals need to schedule appointments, bill patients and insurance companies, and manage patient records; and health insurance companies must enroll patients, process claims, and pay doctors. CHCF contends that those activities have become overly complex and cumbersome in the United States (U.S.) health system. The U.S. spends five times more on administrative health care functions than other wealthy nations, on average. The U.S. employs 44% more administrative health care staff than Canada. There are many contributors to this problem, like inefficient prior authorization processes and incompatible data systems. Complex billing processes, which are being addressed in this bill, are another driver. Inconsistent policies and procedures between providers and insurers can cause confusion, denials, delays, and increased costs.

b) **Downcoding vs. Upcoding.** The California Medical Association (CMA), sponsor of this bill, argues that downcoding is a billing policy employed by insurers that is driving up costs while negatively impacting access to care. Downcoding occurs when a plan or insurer alters a claim submitted by a provider to a lower-cost service code, resulting in a lower level of reimbursement. Some insurers have recently proposed automatic downcoding policies that would systemically reduce reimbursement to physician practices based on an algorithm. Background provided to this committee by the author and CMA argues that this practice is designed to systematically disincentivize providers from billing higher-level codes, even when those codes most accurately align with national standards. The proponents further argue that instead of conducting a legitimate review, insurers reduce payments first and force physicians to navigate a complex appeals process to dispute unjust payment reductions, wasting physician and staff resources and time. Downcoding may also lead physicians to limit the amount of care they can provide in an appointment instead of combining care into one longer appointment, resulting in patients having to schedule multiple appointments to get the same care. According to a press release published by CMA, health plan automatic downcoding policies have been paused in California as they undergo review by DMHC.

   In contrast to physician concerns about the impacts of downcoding policies, there is a growing body of evidence that upcoding by providers is increasing in prevalence and driving up health care costs. Upcoding is a practice when a provider submits a claim to an insurer using higher-level complexity codes than the services actually performed, which leads to a higher level of reimbursement. A 2025 study by Trilliant Health titled, "Changes in Coding Intensity Suggest How Upcoding Is Happening Across Outpatient Settings," found that from 2018 to 2023 the share of visits coded at higher complexity levels increased across all outpatient settings, including physician offices, emergency departments, and urgent care centers. A 2021 report by the U.S. Department of Health and Human Services Office of Inspector General found that hospitals are increasingly billing inpatient stays at the highest severity level, raising concerns about systematic upcoding. From 2014 to 2019, these high severity stays grew by nearly 20%, representing almost half of all Medicare inpatient hospital spending. A 2024 RAND report analyzed hospital claims data from 2011 to 2019 in five states and found the number of patient

discharges documented as needing the highest-intensity care increased by 41%. Adjusting for changes in patient demographics, pre-existing comorbidities, length-of-stay, and hospital characteristics, researchers estimated that the increase would have been 13% in the absence of changes in coding behavior. RAND estimated that in 2019 alone this increase in hospital upcoding was associated with $14.6 billion in hospital payments spread across commercial and government payers.

This bill proposes that every decision to downcode a claim is made by a licensed physician or provider. Given the rise in upcoding practices, this policy could further contribute to the state's 25% problem by increasing the cost and burden of making such determinations.

3) **SUPPORT.** CMA is sponsoring this bill, stating that insurers are increasingly relying on "claim-editing" algorithms to automatically downcode claims without requesting or reviewing relevant clinical records. CMA argues that instead of conducting a legitimate review, insurers reduce payments first and force physicians to appeal if they want to recover the appropriate reimbursement, wasting physician and staff resources and time. CMA continues that health insurers are acting in bad faith, effectively rewriting the rules of medical coding behind closed doors, and disregarding physician expertise and nationally recognized coding standards. CMA believes these policies wrongly reduce payments to physicians and disproportionately impact physicians caring for patients with complex, chronic, or acute needs. CMA notes that at a time when California faces a shortfall of physicians, these automatic downcoding policies threaten the viability of physician practices that communities rely on. CMA concludes that inappropriate downcoding ultimately worsens access to timely care, disrupts patients' continuity of care, and compromises their long-term health.

4) **OPPOSITION.** The California Association of Health Plans and Association of California Life and Health Insurance Companies are opposed to this bill. The opposition argues that as drafted, this bill misunderstands the role of coding validation in the claims payment process and would create operational, cost, and compliance challenges without improving patient care. The opposition continues that preventing plans from using tools that providers themselves rely on could further drive health care costs and ultimately increase premiums for consumers. The opposition notes that coding validation is an administrative process, not a clinical judgment about the appropriateness of care. The opposition continues that this bill focuses exclusively on limiting health plan/insurers oversight while leaving provider coding practices largely unaddressed. The opposition notes that coding validation exists in response to well documented concerns about upcoding and rising coding intensity, particularly for evaluation and management services. The opposition states that improperly documented high-intensity claims inflate costs that are ultimately passed on to consumers and employers. The opposition concludes that this bill would disrupt longstanding claims payment processes, increase administrative burdens, undermine program integrity, and raise health care costs without improving patient outcomes.

5) **PREVIOUS LEGISLATION.** SB 1120 (Becker), Chapter 879, Statues of 2024, requires health plans and disability insurers, including specialized plans and insurers, that use AI, and other software tools used for utilization review or utilization management decisions to comply with specified requirements, including that it be based on an enrollee or insured's medical history and individual clinical circumstances, and be fairly and equitably applied.

Prohibits the AI, algorithm, or other software tool from denying, delaying, or modifying health care services based, in whole or in part, on medical necessity and requires such determinations to be made only by a licensed physician or a licensed health care professional, as specified.

6) **DOUBLE REFERRAL.** This bill is double referred: upon passage in this Committee, this bill will be referred to the Assembly Committee on Privacy and Consumer Protection.

7) **PROPOSED AMENDMENTS.**

   a) **Imbalanced approach.** Given the ample evidence of increasing instances of provider upcoding leading to increased health care spending, there is legitimate concern about this bill's limited focus on health plan downcoding practices. More data is needed to fully understand the impact of both down- and up-coding practices in California and their impacts on claims processes and consumer costs before significant changes are made to existing processes. To address these concerns, the committee is proposing two amendments that:

      **i)** Strike the ban on a plan or insurer's ability to utilize software to make downcoding decisions and the requirement that a licensed physician or provider make downcoding decisions.

      **ii)** Require DMHC and CDI to utilize existing reporting streams, and collect new data where needed, to compile a report on impact of plan downcoding and provider upcoding, including the impact of automated systems, and impacts on the cost of care, financial viability of provider practices, and care delivery.

   b) **Author's amendment.** The author is proposing amendments to conform guardrails in the bill that determine what needs to be considered before downcoding with current claims settlement regulations under DMHC.

**REGISTERED SUPPORT / OPPOSITION**:

**Support**

California Medical Association (sponsor)
American College of Obstetricians & Gynecologists - District IX
California Academy of Family Physicians
California Alliance of Child and Family Services
California Chapter American College of Cardiology
California Children's Hospital Assn
California Chronic Care Coalition
California Hospital Association
California Orthopedic Association
California Podiatric Medical Association
California Primary Care Association
California Radiological Society
California Retired Teachers Association
California Rheumatology Alliance
California Society of Dermatology & Dermatologic Surgery

California Society of Pathologists
Indivisible CA: StateStrong
Physician Association of California
Planned Parenthood Affiliates of California
Providence
Sharp Healthcare
U.S. Pain Foundation

**Opposition**

Association of California Life & Health Insurance Companies
California Association of Health Plans

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