

Date of Hearing: May 6, 2026

ASSEMBLY COMMITTEE ON APPROPRIATIONS

Buffy Wicks, Chair

AB 2431 (Patel) – As Amended April 9, 2026

Policy Committee: Health

Vote: 16 - 0

Urgency: No

State Mandated Local Program: Yes

Reimbursable: No

**SUMMARY:**

This bill prohibits a health plan and health insurer (collectively, health plan) from downcoding a claim based solely on information reported on the claim form. The bill requires a health plan's determination to downcode a claim to include a documented review of the relevant clinical information supporting the billed service.

Specifically, this bill:

- 1) Defines “downcoding” to mean the unilateral alteration by a payer of the service or procedure code submitted on a claim, resulting in a lower payment.
- 2) Requires a health plan's determination to downcode a claim to include a documented review of the relevant clinical information supporting the billed service, pursuant to applicable national coding guidelines.
- 3) Prohibits a health plan from downcoding a claim based solely on information reported on the claim form.
- 4) Requires a health plan to notify and provide the billing provider with a clear explanation if a claim has been downcoded, specific reasons for the action taken, and other information, including the specific reasons for downcoding, and a notice of the dispute resolution mechanism described in item 5), below.
- 5) Requires a health plan to provide a billing provider with a clear and accessible process for disputing downcoded claims, with a timeline that is no less than 365 days from the plan's or capitated provider's most recent action, or less than 365 days, in the case of inaction.
- 6) Requires a health plan to adjudicate a provider dispute and issue a written determination stating the pertinent facts and reasons for the determination within 45 working days of receipt of a provider dispute or amended provider dispute.
- 7) 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, and provides that such actions are subject to enforcement actions, including fines, restitution, or suspension of licensure.

- 8) Authorizes the director of the Department of Managed Health Care (DMHC) and the Insurance Commissioner to enforce violations of the provisions of this bill by applying any of a variety of penalties.

#### **FISCAL EFFECT:**

DMHC estimates total costs of approximately \$1.42 million in fiscal year (FY) 2026-27, \$1.51 million in FY 2027-28, \$1.72 million in FY 2028-29, and \$1.7 million in FY 2029-30 and annually thereafter (Managed Care Fund). Most of these costs would be incurred by DMHC's Help Center, Office of Financial Review (OFR), and Office of Enforcement (OE). The Help Center anticipates an increased number of provider complaints and the need for three additional staff. The OFR anticipates additional workload to review claims processing policies and procedures, which would require five additional staff. The OE anticipates additional enforcement referrals from the OFR and Help Center for compliance and the need for one additional staff.

The Department of Insurance estimates costs of \$1.09 million in FY 2026-27, \$1.13 million in FY 2027-28, \$1.09 million in FY 2028-29, \$1.09 million in FY 2029-30, \$1.24 million in FY 2030-31, and \$1.09 million in FY 2031-32 and ongoing (Insurance Fund). These costs include consulting; project oversight; coordination with DMHC; development of data systems and validation rules; creation and maintenance of data collection tools; insurer outreach and support; ongoing data compilation and quality assurance; compliance monitoring; analysis and reporting; development of public facing reporting; and enforcement.

#### **COMMENTS:**

- 1) **Purpose.** This bill is sponsored by the California Medical Association (CMA). According to the author:

California already faces a serious shortage of primary care physicians. [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. This bill ensures that any reduction in payment is grounded in an actual clinic review and not software algorithms. When we protect physicians' ability to practice sustainably, we protect patients' access to the care they deserve.

- 2) **Background.** 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. The author and sponsor suggest this practice is designed to disincentivize providers from billing higher-level codes, even when those codes are appropriate, and 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. According to a press release published by CMA, health plan automatic downcoding policies have been paused in California as DMHC reviews the policies.

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. There is a growing body of evidence that upcoding by providers is increasingly prevalent and driving up health care costs. A 2025 study by Trilliant Health 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. The U.S. Department of Health and Human Services Office of Inspector General reported in 2021 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. RAND estimated that in 2019 alone the increase in apparent hospital upcoding was associated with \$14.6 billion in hospital payments spread across commercial and government payers.

**Analysis Prepared by:** Allegra Kim / APPR. / (916) 319-2081