SENATE COMMITTEE ON HEALTH
Senator Akilah Weber Pierson, Chair

BILL NO: AB 2499
AUTHOR: Gipson
VERSION: June 22, 2026
HEARING DATE: July 1, 2026
CONSULTANT: Teri Boughton

SUBJECT: Health care coverage: claims payments

SUMMARY: Requires a health plan or insurer to accept, and confirm, electronic medical records and supporting documentation necessary to process a claim through a standard electronic submission method, and prohibits a plan or insurer from denying, pending, or delaying a claim solely because the plan's or insurer's systems are unable to accept documentation that otherwise meets state requirements.

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 and the California Department of Insurance to regulate health and other insurers under the Insurance Code. [HSC §1340, et seq., and INS §106, et seq.]

2) Requires plans and insurers to reimburse a completed claim within 30 calendar days after receipt, and notify a claimant, in writing, that the claim is contested or denied, as soon as practicable, but no later than 30 calendar days after receipt of the claim. Makes a claim reasonably contested if the plan has not received the completed claim and all information necessary to determine payer liability or the plan or insurer has not been granted reasonable access to information concerning provider services. [HSC §1371 and INS §10123.13]

3) Requires, if a claim or portion of the claim is contested on the basis that the plan or insurer has not received all information necessary to determine payer liability for the claim, the plan or insurer has 30 calendar days after receipt of additional information to complete reconsideration of the claim. Requires, if a plan or insurer has not received all information to determine payer liability, and a notice has been provided, to have 30 calendar days after receipt of additional information to complete reconsideration of the claim. Requires, if the plan has received all the information and has not reimbursed a claim within 30 calendar days, interest to accrue. [HSC §1371 and INS §10123.13]

4) Establishes the California Health and Human Services Data Exchange Framework (data exchange framework) that includes a single data sharing agreement and common set of policies and procedures to leverage national standards for information exchange and data content and govern and require the exchange of health information among health care entities and government agencies in California. [HSC §130290, et. seq]

5) Requires, by January 31, 2024, health care organizations such as hospitals, physician organizations, and skilled nursing organizations to exchange health information or provide access to health information to and from other required health care organizations in real time as specified by the Department of Health Care Access and Information (HCAI) pursuant to the data exchange framework data sharing agreement for treatment, payment, or health care operations with some exceptions for health care organizations, such as specified clinics,

required to exchange or provide access to health information by July 1, 2026. [HSC §130290]

6) Defines "health information" to mean:
   a) For hospitals, skilled nursing facilities, clinical laboratories, and physician organizations and medical groups, all electronic health information as defined under federal regulation and held by the entity. Requires this information pursuant to this subparagraph to be at a minimum the information included in specified federal regulations as of April 15, 2025. In accordance with the data exchange framework data sharing agreement and policies and procedures, a signatory to the data sharing agreement is not required to share information that is not maintained by the entity; and,
   b) For health insurers and health plans, at a minimum, the data required to be shared under the federal Centers for Medicare and Medicaid Services (CMS) Interoperability and Patient Access regulations for public programs as contained in a specified federal rule as of April 15, 2025. [HSC §130290]

This bill:

1) Requires a health plan or insurer to accept electronic medical records and supporting documentation necessary to process a claim through a standard electronic submission method.

2) Requires a health plan or insurer to confirm receipt electronically and prohibits a plan/insurer from denying, pending, or delaying a claim solely because the plan/insurer's systems are unable to accept documentation that otherwise meets stated requirements.

3) Defines "electronic submission" as submission through an electronic portal designated by the plan or an electronic submission in accordance with the data exchange framework and applicable federal interoperability rules.

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

PRIOR VOTES: Not relevant

COMMENTS:

1) *Author's statement.* According to the author, healthcare providers and health insurers spend countless hours and billions of dollars on claims processing. Many healthcare providers are still required to manually fax or mail patient health documents to health insurers due to system file size limitations. This administrative burden causes delays in patient care, increases the chance of inadvertently exposing protected health information (PHI), and draws healthcare resources away from direct patient care. This bill addresses that by modernizing how health insurers process claims in California. Right now, many health plans rely on outdated systems that make it hard for providers to submit the necessary information for care reimbursement. As a result, claims sit in limbo, offices spend extra time tracking down payments, and in some cases, patients get caught in the middle and their data is at risk. By modernizing the claims process, this bill would reduce patient confusion, cut down on delays that can slow down care, and protect PHI by moving away from paper-based and manual processes that create unnecessary risk. When claims move through the system smoothly, providers can focus on care, patients get clearer answers, and California's healthcare system becomes more efficient, ensuring valuable healthcare resources are dedicated to directing patient care.

2) *21st Century Cures Act and federal rules.* This federal law was signed in 2016 and covers a wide range of topics from biomedical research to prevention and public health. According to a report by the Congressional Research Service, Title IV promotes the adoption and use of electronic health record technology. Final rules seek to improve interoperability by requiring certified health information technology products to adopt new and updated vocabulary and content standards, including common clinical data composed of standardized data elements and improving health information systems to transmit, receive, and use standardized clinical documents. The Office of the National Coordinator (ONC) has developed an interoperability road map which discusses the payment and regulatory drivers for promoting interoperability, and policy and technical components of a fully interoperable nationwide health information infrastructure. Challenges identified were legal and governance barriers to trusted information exchange. According to the federal ONC, there is a Trusted Exchange Framework and Common Agreement which outlines a common set of principles, terms, and conditions to support the development of a common agreement that helps enable the nationwide exchange of electronic health information across disparate health information networks. It is designed to scale electronic health information exchange nationwide and help ensure the health information networks, health care providers, health plans, individuals, and many more stakeholders have secure access to their electronic health information. A 2020 Final Rule issued by CMS indicates more than 95% of hospitals and 75% of office-based clinicians are utilizing certified health information technology, but challenges remain in creating a comprehensive, longitudinal view of a patient's health history.

3) *Data exchange framework.* California's data exchange framework requires acute and psychiatric hospitals, physician organizations and medical groups, skilled nursing facilities, health plans, clinical labs, and other health and social service organizations who voluntarily choose to participate, (participants/signatories) to sign the data exchange agreement and exchange health and human services information in real time starting on January 31, 2024. The data exchange framework is not a centralized data repository; instead, it is when participants agree to follow rules of the road for securely and appropriately exchanging health and social services information to best serve patients and join a shared commitment to providing safe, effective, whole-person care across California. The law requires required signatories to the data sharing agreement, which includes health insurers and health plans, to exchange health information or provide access to health information to and from every other required signatory. The date exchange law defines "health information" for health insurers and health care service plans as, "at a minimum, the data required to be shared under the federal CMS Interoperability and Patient Access regulations for public programs as contained in United States Department of Health and Human Services final rule. The CMS final rule requires entities to share adjudicated claims, encounter information, and clinical data contained in the United States Core Data for Interoperability.

4) *Standards for Health Care Claims Attachments.* A March 2026 CMS Fact Sheet on a Final Rule related to Administrative Simplification describes the first-ever Health Insurance Portability and Accountability Act- adopted standards for health care claims attachments, enabling the secure electronic exchange of health care claims-related supporting clinical documentation such as medical records, x-rays and imaging, clinical notes, telemedicine visit documentation and laboratory results. The rule also establishes requirements for electronic signatures to ensure health care claims attachment transactions are secure, authenticated, and compliant with federal standards. According to the fact sheet, eliminating manual processes such as faxing and mailing, are projected to save the health care industry roughly $781

million annually; reduce administrative burden; accelerate claims processing, ensure secure, authenticated electronic exchanges, and streamline workflows for both providers and payers. Compliance deadlines for these standards are set for 24 months from the effective date of the final rule, which was May 26, 2026.

5) *Prior legislation.* SB 660 (Menjivar, Chapter 325, Statutes of 2025) transfers the responsibility of the data exchange framework and data sharing agreement and its policies and procedures to HCAI. SB 660 also excludes from the requirement to exchange health information, gender affirming care, immigration or citizenship status, or place of birth.

   AB 3275 (Soria and Robert Rivas, Chapter 763, Statutes of 2024) requires a health plan, including a Medi-Cal managed care plan, or a health insurer, including specialized health plans or insurers, to reimburse a complete claim or a portion thereof within 30 calendar days after receipt of the claim, or, if a claim or portion thereof does not meet the criteria for a complete claim or portion thereof, to notify the claimant as soon as practicable, but no later than 30 calendar days that the claim is contested or denied. AB 3275 authorizes DMHC or CDI to issue guidance and regulations related to this bill. AB 3275 exempts the guidance and amendments from the Administrative Procedure Act until December 31, 2027. AB 3275 requires a complaint made by an enrollee to a health plan about a delay or denial of a payment of a claim to be treated as a grievance subject to that grievance process.

   AB 133 (Committee on Budget, Chapter 143, Statutes of 2021), among other provisions, establishes a process for developing the California Health and Human Services data exchange framework, including the components and milestones related to the stakeholder advisory group, establishing the data exchange framework; health care organization adoption of the data exchange framework; and, real-time health information exchange.

6) *Support.* Providence St. Joseph Health, this bill's sponsor, writes this bill offers a narrow and practical solution by requiring plans and insurers to accept electronic medical records and supporting documentation necessary to process a claim through standard electronic submission methods, while preserving existing coverage rules, patient privacy, medical necessity standards, claims adjudication standards, and the ability of a plan or insurer to request information necessary to determine payer liability. This bill modernizes the method by which providers may submit records and documentation that plans insurers already request. The sponsors indicate that publicly available payer guidance illustrates that large payers have varying size limits per transaction, attachment limits, and rejection codes when attachments exceed certain limits. The sponsors indicates that a 100 MB cap is modest relative to ordinary business and consumer file-transfer tools which allow file uploads ranging from 1GB to several terabytes depending upon the platform. Adventist Health writes hospitals and care teams are often required to manually fax thousands of pages of medical records to payers due to restrictive file size limits or a lack of viable electronic submission systems, which divert clinical staff from patients. Additionally, Adventist Health indicates delays caused by lost, incomplete, or misfiled faxed documents can slow claims processing and reimbursement, creating administrative burdens that ultimately affect patients. By enabling fast, reliable electronic submissions, this bill will help ensure that claims are processed more efficiently. Transitioning away from fax-based systems enhances patient privacy protections by reducing the risk of misdirected faxes and unintended disclosures of sensitive health information.

7) *Opposition.* The California Association of Health Plans (CAHP) and the Association of California Life and Health Insurance Companies (ACLHIC) indicate it is unclear what specific problem this bill is attempting to solve as health plans already widely accept electronic claim submissions and have invested heavily in interoperable systems, provider portals, and clearinghouse infrastructure. CAHP and ACLHIC believe the vast majority of claims are submitted and adjudicated electronically today without issue. CAHP and ACLHIC feel this bill is one sided and should require providers to submit claims and/or prior authorization requests electronically using plan-designated portals or existing interoperability standards. They are very concerned that this bill would prohibit them from denying, pending, or delaying claims when system limitations prevent the receipt of necessary documentation. CAHP and ACLHIC feel this creates risk of improper payments.

8) *Policy comments.*
   a) This bill may be premature given that claims submission standards have only recently been released, and compliance is not required until May of 2028.
   b) In the near term it may be unwise and unreasonable to prevent plans from denying, pending, or delaying claims. Allowances should be made for unforeseen circumstances.

9) *Amendments.* The Committee may wish to amend this bill as follows in response to the policy comments:

   (7) (A) **Commencing May 26, 2028, a** plan shall accept electronic medical records and supporting documentation necessary to process a claim through a standard electronic submission method. A plan shall confirm receipt electronically and shall not deny, pend, or delay a claim solely because the plan's systems are unable to accept documentation that otherwise meets stated requirements. **This paragraph does prohibit a plan from denying, pending, or delaying a claim to the extent authorized under law. This paragraph shall not apply during the period in which a plan's ability to accept electronic medical records and supporting documentation is impacted by circumstances outside the plan's reasonable control, including power outages, natural disasters, or cybersecurity attacks or incidents adversely impacting a plan's ability to process an electronic submission.**
   (B) For purposes of this paragraph, "electronic submission" means submission through an electronic portal designated by the plan or an electronic submission in accordance with Section 130290 and applicable federal interoperability rules.

   (C) If a state or federal standard is adopted specific to file size, number, or other capacity requirements for claims-related supporting documentation submission, that standard shall apply.

SUPPORT AND OPPOSITION:

Support: Providence St. Joseph Health (sponsor)
Adventist Health
Alliance of Catholic Health Care, Inc.
California Orthopedic Association
California Podiatric Medical Association
Harbor Community Health Centers
Healdsburg Hospital Community Board
Humboldt County Community Ministry Board
Loma Linda University Adventist Health Sciences Center

Orange County Business Council
Petaluma Valley Hospital Community Board
Providence Little Company of Mary Foundation Board
Providence Mission Hospital Community Ministry Board
Providence St. Mary Medical Center Community Ministry Board
Queen of the Valley Medical Center Community Board
Santa Rosa Memorial Hospital Community Board
St. Jude Medical Center Board of Trustees
Saint Joseph Hospital Community Ministry Board
Valley Industry and Commerce Association

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

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