

Date of Hearing: April 21, 2026

ASSEMBLY COMMITTEE ON HEALTH  
Mia Bonta, Chair  
AB 2613 (Sharp-Collins) – As Amended March 19, 2026

**SUBJECT:** Health care service plans: provider network transitions.

**SUMMARY:** Requires a health plan to automatically reinstate an enrollee to their previously assigned primary care provider or provider group if a provider network transition is materially delayed, terminated, rescinded, or otherwise fails, as specified. Specifically, **this bill:**

- 1) Requires, if a provider network transition is materially delayed, terminated, rescinded, or otherwise fails within 120 days of an enrollee reassignment conducted under existing law, the health plan to automatically reinstate the enrollee to the enrollee’s previously assigned primary care provider or provider group, if they remain contracted with the plan.
- 2) Requires automatic reinstatement to occur without any of the following:
  - a) A request from the enrollee;
  - b) A continuity of care determination; or,
  - c) A grievance or appeal filed by the enrollee.
- 3) Requires a health plan to provide written notice within five business days of the reinstatement that includes all of the following:
  - a) Confirmation of reassignment to the prior provider;
  - b) Information regarding the enrollee’s right to select a different provider; and,
  - c) Contact information for assistance in scheduling care.
- 4) Requires, if a provider network transition is materially delayed, terminated, rescinded, or otherwise fails within 120 days of an enrollee reassignment and the provider is no longer contracted with the plan, the plan to do one of the following:
  - a) Offer continuity of care; or,
  - b) Arrange for out-of-network care at in-network cost sharing until a reassignment that complies with existing law can be effectuated.
- 5) Requires a reinstatement conducted pursuant to this section to not be deemed a new transfer.
- 6) Defines “provider network transition” to include a merger, acquisition, affiliation, or contractual arrangement that results in the reassignment of enrollees to a different primary care provider, provider group, or health facility.

**EXISTING LAW:**

- 1) Establishes the Department Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975. [Health and Safety Code (HSC) § 1340, *et seq.*]
- 2) Requires, at least 75 days before a termination date of a contract with a provider group or general acute care hospital, a health plan to submit an enrollee block transfer filing to DMHC that includes the written notice the plan proposes to send to affected enrollees. Prohibits the plan from sending the notice to enrollees until DMHC has reviewed and approved its content, unless DMHC does not respond within seven days of the date of its receipt of the filing. [HSC § 1373.65]
- 3) Requires, at least 60 days before a termination date of a contract with a provider group or general acute care hospital, a health plan to send the written notice described in 2) above by mail to enrollees who are assigned to the terminated provider group or hospital, as specified. [*Ibid.*]
- 4) Requires, if the plan and provider reach an agreement to renew or enter into a new contract or to not terminate the contract after sending the notice required in 3), the plan to offer each affected enrollee the option to return to that provider. Requires, if the enrollee does not exercise this option, the plan to reassign the enrollee to another provider. [*Ibid.*]
- 5) Requires a health plan and provider to include in all written, printed, or electronic communications sent to an enrollee that concern the contract termination or block transfer, the following statement in not less than 8-point type: “If you have been receiving care from a health care provider, you may have a right to keep your provider for a designated time period. Please contact your health plan’s customer service department, and if you have further questions, you are encouraged to contact the Department of Managed Health Care, which protects consumers, by telephone at its toll-free number, 1-888-466-2219, or at a TDD number for the hearing and speech impaired at 1-877-688-9891, or online at [www.dmhc.ca.gov](http://www.dmhc.ca.gov).” [*Ibid.*]
- 6) Requires health plans to cover the completion of covered services by a terminated provider, if requested by an enrollee or insured for the treatment of certain conditions, and if the provider and plan agree on terms and reimbursement, as specified. Requires health plans to cover the completion of covered services by non-participating providers for new enrollees under similar circumstances. [HSC § 1373.96]

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

**COMMENTS:**

- 1) **PURPOSE OF THIS BILL.** According to the author, across California, patients are increasingly caught in the middle of disputes and network changes driven by large health systems and insurance company negotiations. The author continues that when contracts break down or networks shift, patients are often reassigned to new providers with little notice. The author notes that at the same time, our notification laws remain stuck in the past. The author states that health plans continue to rely on paper mail as the primary method of communication, even as most Californians live and communicate in a digital world. The

author argues that these notices are often delayed, inaccessible, or never received, leaving patients unaware of major changes until they are denied care or faced with unexpected costs. The author concludes that this bill requires automatic reinstatement of patients to their original provider when a network transition fails and modernizes notification requirements by allowing health plans to communicate through timely electronic methods, so patients receive critical information without delay.

- 2) **BACKGROUND.** A block transfer occurs when a health plan moves a block of members all at once from a terminated provider group or hospital to a new one. This occurs when a contract between a health plan and the provider group or hospital is terminated or is not renewed. To ensure that enrollees aren't left without access to care upon termination, health plans are required to plan and arrange for the transfer to new providers ahead of the termination date. Current state law and regulations require health plans to submit a block transfer filing to DMHC at least 75 days before a potential contract termination date, DMHC must subsequently review impacts and notifications that will be sent out to enrollees. After DMHC's review, plans are then statutorily required to notify enrollees by mail at least 60 days prior to the termination and transfer date. If the contract with the provider is terminated, state law requires health plans to cover the completion of covered services by a terminated provider, if requested by an enrollee for the treatment of certain conditions, and if the provider and health plan agree on terms and reimbursement. Additionally, if the provider contract is reinstated the health plan must offer the enrollee the option to return.
- 3) **OPPOSITION.** The California Association of Health Plans (CAHP) and Association of California Life and Health Insurance Companies (ACLHIC) oppose this bill, stating that health plans are already required to follow strict timelines for block transfer notices, which ensure enrollees do not experience a gap in coverage, access issues, or unnecessary interruptions in care. CAHP and ACLHIC note that timelines and notifications under current law help prevent disruptions in care if a contract is ultimately terminated. CAHP and ACLHIC continue that in some cases, enrollees may receive a notice and proactively choose a new provider before the potential termination date. CAHP and ACLHIC argue that requiring plans to move those enrollees back to their original provider, as this bill proposes, would be inappropriate and counterproductive. CAHP and ACLHIC continue that such an approach would disrupt patient choice and could result in moving patients without their consent, which is particularly problematic after care decisions have already been made. CAHP and ACLHIC state that this approach would also create billing conflicts and unnecessary confusion for enrollees. CAHP and ACLHIC argue that if a plan reaches an agreement with a terminated provider, existing law already requires the plan to offer enrollees the option, but not the obligation, to return. CAHP and ACLHIC continue that the out-of-network coverage approach in this bill undermines the core purpose of provider networks, which are designed to promote quality, coordinated, and cost-effective care. CAHP and ACLHIC conclude that by effectively guaranteeing in-network reimbursement rates outside of negotiated contracts, the proposal would disincentivize providers from reaching agreements with plans/insurers during contract negotiations.
- 4) **OPPOSED UNLESS AMENDED.** The Local Health Plans of California (LHPC) also oppose this bill, arguing that as drafted this bill creates significant operational conflicts, as Medi-Cal plans are already subject to strict 30-day and 60-day notification requirements for provider terminations under current state law and regulations. LHPC continues that adding the automatic reinstatement and specific written notices required by this bill creates "noticing

fatigue" and potential confusion for Medi-Cal beneficiaries. Additionally, LHPC notes that the Medi-Cal program and Knox-Keene requirements already provide robust continuity of care protections (often up to 12 months). Finally, LHPC argues that this bill's requirement for in-network cost-sharing during failed transitions is generally not applicable to the Medi-Cal population, as most members do not have the same cost-sharing obligations as commercial enrollees. LHPC is opposed to this bill unless it is amended to exempt Medi-Cal Managed Care plans, or at least, be modified to align with existing guidance on member transitions.

- 5) **AMENDMENTS.** There are robust state laws and regulations guiding the block transfer process, timelines, and notification requirements. Existing law also provides pathways for enrollees to pursue continued care with a terminated provider, and requires that they are offered the option to be reassigned to any terminated provider that rejoins their network. However, the author has identified a gap in existing law. Plans are statutorily required to provide notifications by U.S. mail, however in 2026 many people aren't checking their mail on a regular basis and rely on electronic communication methods. The committee may wish to delete the current contents of this bill and instead update existing law to allow health plans to provide electronic or text notifications on contract terminations and pending block transfers, in addition to mail, to ensure that enrollees are receiving the updates they need on the status of their coverage and care.

#### **REGISTERED SUPPORT / OPPOSITION:**

##### **Support**

None on file

##### **Opposition**

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

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