

ASSEMBLY THIRD READING  
AB 2613 (Sharp-Collins)  
As Amended April 27, 2026  
Majority vote

## SUMMARY

Requires a health plan to send written notice via text message or email, in addition to U.S. mail, to an affected enrollee at least 60 days before the termination date of a contract between the health plan and a provider group or a general acute care hospital. If, after sending the notice, the health plan reaches an agreement to continue the contract with the provider group or hospital, this bill requires the health plan to notify the enrollee within 60 days by U.S. mail and either text message or email.

## COMMENTS

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 the Department of Managed Health Care (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.

### **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.

### **Arguments in Support**

Health Access California (HAC) supports this bill, stating that health plans continue to rely on paper mail as the primary method of communication, even while many Californians rely on digital options including email. HAC continues that for low-income patients who may move

often, people with mobility issues or others with limited access to mail for differing reasons, this bill will improve their access to crucial updates from the plans and improve their access to essential care.

### **Arguments in Opposition**

The California Association of Health Plans (CAHP) and Association of California Life and Health Insurance Companies (ACLHIC) were opposed to a previous version of 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.

### **FISCAL COMMENTS**

According to the Assembly Committee on Appropriations, minor and absorbable costs to DMHC.

### **VOTES**

#### **ASM HEALTH: 16-0-0**

**YES:** Bonta, Chen, Addis, Aguiar-Curry, Ahrens, Caloza, Carrillo, Mark González, Johnson, Patel, Patterson, Rogers, Sanchez, Schiavo, Sharp-Collins, Stefani

#### **ASM APPROPRIATIONS: 15-0-0**

**YES:** Wicks, Hoover, Bauer-Kahan, Calderon, Caloza, Ellis, Fong, Mark González, Krell, Pacheco, Pellerin, Sharp-Collins, Solache, Ta, Tangipa

### **UPDATED**

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