THIRD READING

Bill No: AB 2613
Author: Sharp-Collins (D), et al.
Amended: 6/29/26 in Senate
Vote: 21

SENATE HEALTH COMMITTEE: 11-0, 6/24/26
AYES: Weber Pierson, Valladares, Caballero, Durazo, Gonzalez, Grove, Menjivar, Padilla, Pérez, Rubio, Smallwood-Cuevas

SENATE APPROPRIATIONS COMMITTEE: Senate Rule 28.8

ASSEMBLY FLOOR: 74-0, 5/21/26 - See last page for vote

SUBJECT: Health care service plans: provider contract termination: notice

SOURCE: Author

DIGEST: This bill 1) requires a health plan in a contract renewal dispute with a provider group or hospital to notify affected enrollees by text or email, if the enrollee has opted into electronic delivery and has included the necessary contact information, in addition to existing requirements to provide a notice by U.S. mail, 60 days before the termination date; and 2) requires, if the contract dispute is resolved, the affected enrollees to be notified by text or email and U.S. mail within 60 days of reaching agreement that the enrollee has an option to return to their provider, or the plan will reassign the enrollee to another provider.

ANALYSIS:

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 (Knox-Keene Act). [Health and Safety Code (HSC) §1340, et seq.]

2) Requires a health plan, at least 75 days before the termination date of its contract with a provider group or a hospital, 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 this notice to enrollees until DMHC has reviewed and approved its content. Requires, if DMHC does not respond within seven days of the date of its receipt of the filing, the notice to be deemed approved. Authorizes, if an individual provider terminates the provider's contract or employment with a provider group that contracts with a health plan, the plan to require that the provider group to send the notice. [HSC §1373.65]

3) Requires a health plan, at least 60 days before the termination date of a contract between a health plan and a provider group or a hospital, to send a written block transfer notice by U.S. mail to enrollees who are assigned to the terminated provider group or hospital. [HSC §1373.65]

4) Requires a health plan that is unable to comply with the 60 days prior to termination timeframe because of exigent circumstances to apply to DMHC for a waiver. Makes the plan excused from complying with this requirement only if its waiver application is granted or DMHC does not respond within seven days of the date of its receipt of the waiver application. Requires the plan, if the terminated provider is a hospital and the plan assigns enrollees to a provider group with exclusive admitting privileges to the hospital, to send the written notice to each enrollee who is a member of the provider group and who resides within a 15-mile radius of the terminated hospital. Requires the plan, if it operates as a preferred provider organization or assigns members to a provider group with admitting privileges to hospitals in the same geographic area as the terminated hospital, the plan to send the written notice to all enrollees who reside within a 15-mile radius of the terminated hospital. [HSC §1373.65]

5) Requires a health plan, if after sending the notice required in 2) above it reaches an agreement with a terminated provider to renew or enter into a new contract or does not terminate the contract, to offer each enrollee the option to return to that provider, and if the enrollee does not exercise this option, requires the plan to reassign the enrollee to another provider. [HSC §1373.65]

6) Requires a health plan and a provider to include in all written, printed, or electronic communications sent to an enrollee concerning a 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 DMHC, 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." [HSC §1373.65]

This bill:

1) Requires the health plan, in addition to sending a written notice by U.S. mail regarding the termination of a contract, to send the written notice to the enrollee electronically at least 60 days before the termination date of the contract via either of the following methods if the enrollee has opted into electronic delivery as their communication preference and has included the contact information described below:
   a) Text message to the preferred or last known cell phone number of the enrollee; or,
   b) Email to the preferred or last known email address of the enrollee.

2) Requires when a plan offers affected enrollees the option to return to their provider, if the plan and provider reach an agreement, enter into a new contract, or do not terminate the existing contract, to notify the enrollees in accordance with the following:
   a) Within 60 days of reaching the agreement requires the plan to send written notice by U.S. mail to affected enrollees, and to send written notice to the enrollee electronically within 60 days of reaching the agreement via either of the following methods if the enrollee has opted into electronic delivery as their communication preference and has included the contact information described below:
      i) Text message to the preferred or last known cell phone number of the enrollee; or,
      ii) Email to the preferred or last known email address of the enrollee.

Comments

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 companies. When contracts break down or networks shift, patients are often reassigned to new providers with little notice. At the same time, our notification laws remain stuck in the past. 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. 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. This bill modernizes notification requirements by allowing health plans to communicate through timely electronic methods, so patients receive critical information without delay.

Background

Block Transfer requirements. Before the termination date of its contract with a provider group or a general acute care hospital, health plans must submit an enrollee Block Transfer Filing to DMHC. DMHC reviews these filings to ensure compliance with applicable statutory (Knox-Keene Act) and regulatory (California Code of Regulations title 28) requirements. DMHC's review ensures (1) that the network remains adequate without the terminating provider group or hospital; and, (2) that the impacted enrollees are timely notified of the termination and informed of their rights. If DMHC approves a Block Transfer Filing, the health plan may inform its enrollees of the termination and redirect the enrollees to the alternate providers. During the block transfer filing review, DMHC also requests confirmation that health plans have reached a continuity of care agreement with terminating hospitals and provider groups which specifies reimbursement rates for the completion of covered services.

Continuity of care. Existing law allows an enrollee to request continuity of care when a doctor, medical group or hospital is no longer contracting with a health plan. The provider must agree to keep the enrollee as a patient and agree to the health plan reimbursement. Enrollees with certain conditions can obtain continuity of care if the provider agrees. For example, acute conditions, serious chronic conditions, pregnancy, terminal illness, children under three, or an already scheduled surgery or procedure would qualify. Continuity of care may last as long as the condition exists or may be limited after a course of treatment is completed and the patient can be transitioned to a provider in the plan's network. Enrollee transfer notices must include a website link to the plan's continuity of care policies also called completion of covered services or care, which are reviewed by DMHC. In addition, the health plans' enrollee transfer notices must include details related to the conditions eligible for completion of care, how to request completion of care, and a statement providing information on how enrollees can contact the DMHC's Help Center for assistance.

Notice to request completion of covered services must also be provided to enrollees in every health plan disclosure form and in any evidence of coverage documents. A health plan must also provide this notice to its providers, to its enrollees upon request, along with a specified termination of coverage notice. If enrollees are hospitalized through the emergency room, there are post-stabilization procedures that health plans must follow to authorize continued care at the hospital or to arrange for transfer to an authorized hospital. These procedures would be effective whether the hospital is contracted, non-contracted, or recently terminated.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: Yes

SUPPORT: (Verified 8/3/26)

Health Access California

OPPOSITION: (Verified 8/3/26)

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

ARGUMENTS IN SUPPORT: Health Access California writes, "When contracts break down between health systems and insurance companies, patients are left in the middle. While existing law requires health plans to cover the completion of services by a terminated provider, it is only if requested by the enrollee and if the provider and plan agree on terms and reimbursement. As such, this continued care is often challenging to access. Health plans continue to rely on paper mail as the primary method of communication, even while many Californians rely on digital options including email. 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: *Oppose unless amended.* The California Association of Health Plans (CAHP) and the Association of California Life and Health Insurance Companies (ACLHIC) request an amendment to allow health plans the option of offering their enrollees an electronic delivery notification in lieu of U.S. mail, rather than both. CAHP and ACLHIC believe this bill could delay necessary reassignments because they could occur after the enrollee decides whether they would like to return to their previous provider, so they request reverting the bill back to existing law.

ASSEMBLY FLOOR: 74-0, 5/21/26

AYES: Addis, Aguiar-Curry, Ahrens, Alanis, Alvarez, Ávila Farías, Bains, Bauer-Kahan, Bennett, Berman, Boerner, Bonta, Bryan, Calderon, Caloza, Carrillo, Castillo, Connolly, Davies, DeMaio, Dixon, Elhawary, Ellis, Flora, Fong, Gabriel, Gallagher, Gipson, Jeff Gonzalez, Mark González, Hadwick, Haney, Harabedian, Hart, Hoover, Irwin, Jackson, Johnson, Kalra, Krell, Lee, Lowenthal, Macedo, McKinnor, Muratsuchi, Nguyen, Ortega, Pacheco, Papan, Patel, Patterson, Pellerin, Petrie-Norris, Quirk-Silva, Ransom, Michelle Rodriguez, Rogers, Blanca Rubio, Sanchez, Schiavo, Schultz, Sharp-Collins, Solache, Soria, Stefani, Ta, Tangipa, Valencia, Wallis, Ward, Wicks, Wilson, Zbur, Rivas
NO VOTE RECORDED: Arambula, Chen, Garcia, Lackey, Ramos, Celeste Rodriguez

Prepared by: Teri Boughton / HEALTH / (916) 651-4111
8/5/26 15:12:53

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