DEPARTMENT OF Managed Health Care

Gavin Newsom, Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
980 9th Street, Suite 500
Sacramento, CA 95814
Phone: 916-324-8176 | Fax: 916-255-5241
www.DMHC.ca.gov

ALL PLAN LETTER

DATE: April 1, 2025

TO: All Health Care Service Plans[1]

FROM: Pritika Dutt
Deputy Director, Office of Financial Review

SUBJECT: APL 25-007 (OFR) – Assembly Bill 3275 Guidance (Claim Reimbursement)

I. Background and Purpose

The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) under the Knox-Keene Health Care Service Plan Act of 1975, as amended,[2] to provide guidance to health care service plans (plans) on requirements for the processing and reimbursement of claims for health care services with a date of receipt on or after January 1, 2026.

Assembly Bill 3275 (Soria, 2024) amended Health and Safety Code sections 1371 and 1371.35 relating to reimbursement of claims for health care services, and enacted Health and Safety Code section 1371.34 enhancing consumer protections relating to grievances about claims for health care services.

II. Claim Reimbursement Requirements

A. Health Plans Must Reimburse Complete Claims Within 30 Calendar Days

Beginning January 1, 2026, Sections 1371 and 1371.35 require a health plan to reimburse a complete claim, or portion thereof, as soon as practicable but no later than 30 calendar days after receipt of the claim. If a claim, or portion thereof, is contested or denied, the health plan must notify the claimant in writing as soon as practicable, but no later than 30 calendar days after receipt of the claim by the health plan.

---

[1] This APL applies to all commercial and Medi-Cal plans, including specialized plans, EAP plans and restricted/limited plans. This APL does not apply to Medicare Advantage plans that do not have any commercial or Medi-Cal lines of business.
[2] California Health and Safety Code sections 1340 et seq. (Act). References herein to “Section” are to sections of the Act. References to “Rule” refer to the California Code of Regulations, title 28.

As such, plans are required to reimburse a complete claim or a portion thereof with a date of receipt on or after January 1, 2026, within 30 calendar days.[3]

B. Interest on Claims and Penalty for Failure to Pay Interest

Beginning January 1, 2026, if a complete claim is not reimbursed within 30 calendar days after receipt, interest accrues at a rate of 15 percent per year beginning with the first calendar day after the 30-calendar-day period. Additionally, plans must continue to automatically include all accrued interest when making payment on a claim beyond the 30-calendar day requirement.

Beginning January 1, 2026, plans who fail to meet the above interest requirements shall also pay the claimant the greater of either an additional fifteen dollars ($15) or ten percent (10%) of the accrued interest on the claim.[4] The requirements for interest and penalty apply to all claims, including claims for emergency services and care.

C. Receipt and Acknowledgement of Claims

Plans remain required to comply with all requirements for claims settlement practices set forth in Rule 1300.71, including date of receipt and acknowledgment of claims.[5]

D. Requirements for Contested and Denied Claims[6]

Beginning January 1, 2026, plans must contest or deny a claim, or portion of a claim, as soon as practicable but no later than 30 calendar days after receipt of the claim by the plan. Plans must notify the claimant, in writing, that the claim is contested or denied.

The notice that a claim, or portion thereof, is contested shall identify the portion of the claim that is contested, by procedure or revenue code, and the specific information needed from the provider to reconsider the claim, including any defect or impropriety or additional information needed to adjudicate the claim. Plans may not contest a claim that is consistent with the procedure or revenue codes and services approved by prior authorization with appropriate documentation included on the claim.

If a claim or portion thereof is contested on the basis that the plan has not received information reasonably necessary to determine payer liability for the claim or portion thereof, reconsideration of the claim must be completed within 30 calendar days after receipt of the additional information.

[3] Definitions applicable to claim settlement practices, including complete claim, are set forth in regulation at Rule 1300.71(a).
[4] Sections 1371(a)(4) and 1371.35(b), as effective 1/1/2026.
[5] Rule 1300.71(c).
[6] Sections 1371 and 1371.35, as effective 1/1/2026.

The notice that a claim, or portion thereof, is denied shall identify the portion of the claim that is denied, by procedure or revenue code, and the specific reasons for the denial including any defect or impropriety.

III. Provider Dispute Resolution Mechanism Requirements

Section 1367 and Rule 1300.71.38 require health plans and capitated providers that pay claims to have a fast, fair and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes. Rule 1300.71.38, subdivision (f), requires provider disputes to be resolved consistent with applicable law including Sections 1371 and 1371.35, and for a written determination to be issued within 45 working days after the date of receipt of the provider dispute. Rule 1300.71.38, subdivision (g), further requires the payment of any amounts due to a provider as a result of a dispute determination within five working days of the written determination, including all interest and penalties required under Sections 1371 and 1371.35.

If a provider dispute or amended provider dispute involves a claim and is determined in whole or in part in favor of the provider, the plan or the plan's capitated provider shall pay any outstanding monies determined to be due, and all interest and penalties required under Sections 1371 and 1371.35. **Beginning January 1, 2026, consistent with AB 3275, interest and penalty, if applicable, are due on all claim payments that are not reimbursed within 30 calendar days after the date of receipt of a complete claim, including payments resulting from provider disputes.**

Health plans must continue to resolve all provider disputes and amended provider disputes and issue the written determination required by Rule 1300.71.38(f) within 45 working days after the date of receipt of the provider dispute or amended provider dispute.

Plans remain required to comply with all other requirements under the Act and Rules for provider disputes, including time periods for submission and acknowledgment.

IV. Section 1371.34 – Grievances About Delay or Denial of Payment of a Claim

Beginning January 1, 2026, Section 1371.34 is added to the Act, codifying in statute that a complaint made by an enrollee to a plan about a delay or denial of a payment of a claim shall be treated as a grievance, regardless of whether the enrollee uses the term "grievance" as part of the complaint.[7]

Plans shall treat all complaints, grievances, or expressions of dissatisfaction made by a member about a delay or denial of a payment of a claim as a grievance subject to Section 1368 and Rule 1300.68.

[7] Section 1371.34, as effective 1/1/2026.

V. Compliance and Filing Requirements

All claims for health care services received on or after January 1, 2026, must be processed in accordance with applicable law, including Sections 1371 and 1371.35 as amended by AB 3275, Rule 1300.71, and this APL.
Plans shall take all measures necessary to ensure timely and full compliance with AB 3275 and this APL, including making necessary updates to claim systems, provider contracts, service agreements, policies and procedures, notices, disclosure forms, and all other health plan documents.

Plans must also ensure compliance of all delegated entities, including risk-bearing organizations, capitated providers, claims processing organizations, and management services organizations. Plans must also conduct staff training and monitor the compliance of all entities contracted for functions related to claims for health care services.

By **August 1, 2025**, please submit one Amendment filing via eFiling titled "**Compliance with AB 3275**" with an Exhibit E-1 to demonstrate or affirm compliance with AB 3275 and this APL as follows:

- Affirm, beginning January 1, 2026, the plan and the plan's delegated entities will reimburse a complete claim, or portion of a claim, received on or after January 1, 2026, as soon as practicable, but no later than 30 calendar days after receipt of the claim by the plan. Also, affirm that if a claim or portion thereof does not meet the criteria for a complete claim or the criteria for coverage under the plan contract, the claimant shall be notified, in writing, that the claim or portion thereof is contested or denied, as soon as practicable, but no later than 30 calendar days after receipt of the claim by the plan.
- Affirm, beginning January 1, 2026, the plan will automatically pay interest on complete claims received on or after January 1, 2026, that are not reimbursed within 30 calendar days at a rate of 15 percent per year beginning on the first calendar day after the 30-calendar-day period. Further, affirm failure to comply with this requirement on a claim will trigger payment by the plan to the claimant a fee of the greater of an additional fifteen dollars ($15) or 10 percent of the accrued interest on the claim.
- Affirm the notice that a claim or portion thereof is contested will identify the portion of the claim that is contested, by procedure or revenue code, and the specific information needed from the provider to reconsider the claim, including any defect or impropriety or additional information needed to adjudicate the claim.
- Affirm the plan will not contest a claim that is consistent with the procedure or revenue codes and services approved by prior authorization with appropriate documentation included on the claim.

- Affirm the notice that a claim or portion thereof is denied will identify the portion of the claim that is denied, by procedure or revenue code, and the specific reasons for the denial including any defect or impropriety.
- Affirm that if a claim or portion thereof is contested on the basis that the plan has not received information reasonably necessary to determine payer liability for the claim or portion thereof, the plan will complete reconsideration of the claim within 30 calendar days after receipt of the additional information.
- Affirm that a complaint made by an enrollee to a plan about a delay or denial of a payment of a claim will be treated by the plan as a grievance, regardless of whether the enrollee uses the term "grievance" as part of the complaint.
- Review the plan's current provider contracts, contracts with risk-bearing organizations, and plan-to-plan contracts, and explain how the plan will ensure each contract complies with AB 3275 and this APL. Submit, as Exhibit K-1 and/or Exhibit P-5, revised contracts or contract addenda the plan intends to use to ensure compliance with AB 3275 and this APL.
- Submit, as Exhibit II-4, revised claims policies and procedures to be effective by January 1, 2026, demonstrating compliance with AB 3275 and this APL. Explain the plan's staff training and any organizational changes made to ensure timely and accurate reimbursement of claims.
- Submit template member notice(s), as Exhibit I-9, that the plan will use to notify a claimant that the claim or portion thereof is contested or denied.
- Identify each service agreement or contract with a claim processing organization pursuant to Rule 1300.71(e) the plan currently has and explain how the plan will ensure each contract complies with AB 3275 and this APL.
- Specify whether the plan will be entering into a new agreement(s) relating to claims processing or reimbursement, the date by which the plan will submit the filing(s) and documents to the DMHC, and whether such documents will be submitted in this filing or in a separate filing. If the plan contends that its current contracts and agreements are compliant, explain the plan's position and provide the eFiling number for each of the plan's most recently approved contract or agreement, along with the page numbers within the specified documents supporting the plan's explanation.
- Demonstrate the plan's arrangements for oversight, monitoring, and ensuring compliance of all entities delegated claim functions.
- Submit, as Exhibit W-1, revised grievance system policies and procedures demonstrating compliance with Section 1371.34, or provide the eFiling number of the plan's most recently approved grievance policy demonstrating compliance.

- State either:

    - The plan has reviewed its provider contracts, policies and procedures, Administrative Service Agreements, plan-to-plan contracts, Disclosure Forms, notices, Evidences of Coverage, and all other plan documents, and those documents are consistent with the requirements of AB 3275.

OR

    - The plan reviewed its provider contracts, policies and procedures, Administrative Service Agreements, plan-to-plan contracts, Disclosure Forms, notices, Evidences of Coverage, and all other plan documents, and those documents are not consistent with the requirements of AB 3275. The plan will amend these documents to comply with AB 3275 and file those documents per the Act's applicable timeframes, but no later than October 1, 2025.

- If the plan is amending any plan documents, specify the following: (1) the date by which the plan will submit these amended documents to the DMHC, (2) whether the amended documents will be submitted in this filing or in a separate filing, (3) which specific documents will be amended, and (4) which specific documents do not need to be amended.

The DMHC will amend regulations for consistency with AB 3275.

For questions regarding health plan contracts or filing requirements, please contact your plan's assigned OPL reviewer.

For all other questions regarding claim processing requirements or this APL, please contact Pritika Dutt at (916) 324-8137 or Pritika.Dutt@dmhc.ca.gov.