
THIRD READING

Bill No: SB 1049
Author: Weber Pierson (D)
Amended: 4/6/26
Vote: 21

SENATE HEALTH COMMITTEE: 8-1, 3/25/26

AYES: Weber Pierson, Caballero, Durazo, Gonzalez, Menjivar, Padilla, Rubio,
Smallwood-Cuevas

NOES: Grove

NO VOTE RECORDED: Valladares, Pérez

SENATE APPROPRIATIONS COMMITTEE: 5-2, 5/14/26

AYES: Cervantes, Cabaldon, Grayson, Richardson, Wahab

NOES: Seyarto, Dahle

SUBJECT: Health care claims reimbursement

SOURCE: American College of Obstetricians & Gynecologists – District IX
California Medical Association

DIGEST: This bill provides a 90-day opportunity for a health care provider to submit a corrected claim if a health plan or insurer denies a claim or sends a notice of overpayment based on a defect that may be remedied by submitting a corrected claim.

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) and the California Department of Insurance to regulate health and other insurers under the Insurance Code. [Health and Safety Code

(HSC) §1340, et seq., and Insurance Code (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. A claim is 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) Requires an institutional or professional provider to reimburse a health plan or health insurer for overpayment within 30 working days from receiving a notice of overpayment and the amount of overpayment unless the overpayment is contested by the provider. Requires the provider to notify the plan within 30 working days if the provider is contesting the overpayment. Requires the notice that the overpayment is being contested to identify the portion of the overpayment and the specific reasons for contesting the overpayment. Requires interest to accrue if the provider does not reimburse the plan for an uncontested overpayment. [HSC §1371.1 and INS §10123.145]

This bill:

- 1) Requires a health plan or insurer that denies a claim or sends a notice of overpayment for a claim based in whole or in part on a defect that may be remedied by submitting a corrected claim, to give the provider 90 days to submit a corrected claim.
- 2) Prohibits a plan or insurer from denying a corrected claim in accordance with 1) directly above submitted on the grounds that the provider did not submit the

claim within the applicable claim filing deadline other than the deadline specified in 1) directly above.

Comments

According to the author of the bill:

Health care providers should not be penalized for minor errors or subjected to overpayment demands based on correctable defects when the care itself was medically necessary and properly delivered. This bill ensures that providers have a fair opportunity to correct a claim before reimbursement is denied which protects providers from sudden financial strain and helps prevent disruptions in patient care.

Background

1) According to DMHC regulations, an unfair payment pattern is any practice, policy, or procedure that results in repeated delays in the adjudication and correct reimbursement of provider claims. Some of the practices, policies, and procedures that may constitute a basis for a finding that the plan or its capitated provider has engaged in a “demonstrable and unjust payment pattern” are listed below:

- The imposition of a Claims Filing Deadline inconsistent with requirements in three or more claims over the course of any three-month period;
- The failure to forward at least 95% of misdirected claims consistent with requirements over the course of any three-month period;
- The failure to accept a late claim consistent with requirements at least 95% of the time for the affected claims over the course of any three-month period;
- The failure to request reimbursement of an overpayment of a claim consistent with the requirements at least 95% of the time for the affected claims over the course of any three-month period;
- The failure to acknowledge receipt of at least 95% of claims consistent with requirements over the course of any three-month period;
- The failure to provide a provider with an accurate and clear written explanation of the specific reasons for denying, adjusting or contesting a claim consistent with requirements at least 95% of the time for the affected claims over the course of any three-month period;
- The inclusion of contract provisions in a provider contract that requires the provider to submit medical records that are not reasonably relevant, as

defined, for the adjudication of a claim on three or more occasions over the course of any three-month period;

- The failure to establish, upon DMHC’s written request, that requests for medical records more frequently than in 3% of the claims submitted to a plan or its capitated provider by all providers over any 12-month period, was reasonably necessary to determine payer liability for those claims consistent with requirements, except with claims involving emergency or unauthorized services or where the plan establishes reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices;
- The failure to establish, upon DMHC’s written request, that requests for medical records more frequently than in 20% of the emergency services and care professional provider claims submitted to the plan or its capitated providers for emergency room service and care over any 12-month period was reasonably necessary to determine payer liability for those claims consistent with requirements, except where the plan demonstrates reasonable grounds for suspecting possible fraud, misrepresentation, or unfair billing practices;
- The failure to reimburse at least 95% of complete claims with the correct payment including the automatic payment of all interest and penalties due and owing over the course of any three-month period; and,
- The failure to contest or deny a claim, or a portion of, within the timeframes required at least 95% of the time for the affected claims over the course of any three-month period.

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

According to the Senate Appropriations Committee:

DMHC estimates costs of approximately \$271,000 in 2026-27, \$281,000 in 2027-28, and \$273,000 in 2028-29 and annually thereafter for state administration (Managed Care Fund) and CDI indicates no fiscal impact for state administration.

SUPPORT: (Verified 5/14/26)

American College of Obstetricians & Gynecologists – District IX (co-source)

California Medical Association (co-source)

California Alliance of Child and Family Services

California Chapter American College of Cardiology

California Chapter of the American College of Emergency Physicians

California Hospital Association

California Optometric Association

California Psychological Association
California Radiological Society
California Rheumatology Alliance
California Society of Health-System Pharmacists
California Society of Pathologists
California Society of Plastic Surgeons
California State Association of Psychiatrists
Physician Association of California
Planned Parenthood Affiliates of California

OPPOSITION: (Verified 5/14/26)

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

ARGUMENTS IN SUPPORT: The American College of Obstetricians and Gynecologists District IX (ACOG) is the sponsor of this bill. ACOG writes, "... over the past year, obstetrics practices throughout the state received notices that their global obstetric fee claims were paid incorrectly. In April 2025, a Sacramento obstetrics practice received notice from their health plan that the 40 previously paid obstetric claims, spanning June 2023 to February 2025, were "paid incorrectly," creating a \$90,000 "overpayment." Many providers were unaware of this coding requirement, which had apparently existed since 2019 but had never been enforced. Once the providers learned the error involved a missing diagnostic code, the practice promptly resubmitted corrected claims; however, these correct claims were still denied as untimely, because the plan's 90-day filing window (which is 90 days from the date of service) had expired. This resulted in the plan recouping funds by withholding payment for ongoing patient care. This problem could have been avoided if providers were given a fair opportunity to cure before payment was recouped." Planned Parenthood Affiliates of California (PPAC) writes that current claims-filing deadlines can prevent providers from remedying defects, resulting in lost reimbursement, administrative waste, and unnecessary disputes that ultimately disrupt patient care. PPAC believes this bill would establish a uniform right for providers to submit a corrected claim within 90 days following a plan's latest action if that corrected claim would resolve the issue, and the bill would also prohibit health plans from rejecting corrected claims based on filing deadlines. This will help to ensure fair payment, reduce avoidable conflicts, and promote efficient claims processing. The California Hospital Association writes:

When minor, correctable errors are identified after the standard 90-day filing window, existing regulations often prevent hospitals from submitting a correction, even if the service was appropriately delivered, which creates a system where health plans are enriched by denying payment for services based on administrative or technical errors at the expense of the providers who delivered medically necessary care to patients.

ARGUMENTS IN OPPOSITION UNLESS AMENDED: The California Association of Health Plans (CAHP) and the Association of California Life and Health Insurance Companies (ACLHIC) believe this bill would unintentionally create operational challenges and undermine existing timelines, potentially delaying claims resolutions. The opposition is concerned that this bill applies broadly to encompass denials, not just situations involving notices of overpayments. Opponents write:

This bill would undermine existing claims processes and the recent framework established under AB 3275. CAHP and ACLHIC believe the bill is ambiguous and request clarifying terms such as “applicable claim filing deadline,” and “corrected claim,” and confirmation that the claim is complete and contains all required information necessary for resolution.

Lastly, they request response timelines consistent with existing standards.

Prepared by: Teri Boughton / HEALTH / (916) 651-4111
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**** END ****