Date of Hearing: June 23, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1049 (Weber Pierson) – As Amended April 6, 2026

SENATE VOTE: 32-2

SUBJECT: Health care claims reimbursement.

SUMMARY: Grants a provider 90 days to submit a corrected claim after a health plan or health insurer denies a claim or sends notice of overpayment for a claim based on a defect that may be remedied by submitting a corrected claim. Prohibits a plan or insurer from denying a corrected claim on the grounds that the provider did not submit the claim within a deadline other than the one specified under this bill.

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 (CDI) to regulate health and other insurers under the Insurance Code. [Health & Safety Code (HSC) § 1340, *et seq.*, and Insurance Code (INS) § 106, *et seq.*]

2) Prohibits a health plan from engaging in an unfair payment pattern, defined as, engaging in a demonstrable and unjust pattern of reviewing or processing complete and accurate claims that results in payment delays; engaging in a demonstrable and unjust pattern of reducing the amount of payment or denying complete and accurate claims; failing on a repeated basis to pay the uncontested portions of a claim within specified timeframes; and, failing on a repeated basis to automatically include the interest due on claims, as specified. [HSC § 1371.37]

3) 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]

4) 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]

5) 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]

6) Requires the health plan or insurer's notice of overpayment to inform the provider how to access their dispute resolution mechanism. Requires the notice to include the name and address to which the dispute should be submitted and a statement that references the requirement that a provider reimburse overpayment within 30 working days of receipt of the notice unless the provider contests the overpayment within 30 working days. Requires the notice to clearly identify the claim, patient, date of service, and explanation of the basis upon which the plan or insurer believes the amount paid on the claim was in excess of the amount due. Requires the notice to include information on interest that may accrue if deadlines are not met. [*Ibid.*]

7) Requires a health plan or insurer's contract with providers to contain provisions requiring a fast, fair, and cost-effective dispute resolution mechanism under which providers may submit disputes to the plan and requiring the plan to inform its providers upon contracting with the plan, or upon change to these provisions, of the procedures for processing and resolving disputes, including the location and telephone number where information regarding disputes may be submitted. Requires a dispute resolution mechanism to be accessible to noncontracting providers for the purpose of resolving billing and claims disputes. [HSC § 1367 & INS § 10123.137]

8) Permits health insurers with affiliated or subsidiary companies that are licensed under DMHC to use the same provider dispute resolution process established by the affiliated or subsidiary entity. [INS § 10123.137]

FISCAL EFFECT: 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.

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, 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. The author states that this bill ensures that providers have a fair opportunity to correct a claim before reimbursement is denied, protecting providers from sudden financial strain and helping prevent disruptions in patient care.

2) **BACKGROUND**.

   a) **Unfair payment patterns**. DMHC regulations define an unfair payment pattern as any practice, policy, or procedure that results in repeated delays in the adjudication and correct reimbursement of provider claims. Below are a few examples 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:"

i) The failure to forward at least 95% of misdirected claims consistent with requirements over the course of any three-month period;

ii) 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;

iii) 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;

iv) The failure to acknowledge receipt of at least 95% of claims consistent with requirements over the course of any three-month period;

v) 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; or,

vi) 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.

b) Provider reports of hurdles with overpayment claims. According to background submitted by the author and sponsors, over the past year obstetrics practices throughout the state received notices that their obstetric claims were paid incorrectly. The background shared the following example, in April 2025 a Sacramento obstetrics practice received notice from their health plan that 40 previously paid obstetric claims—spanning June 2023 to February 2025—were paid incorrectly, creating a $90,000 overpayment. To make up for the overpayment, the plan began recouping funds by withholding payment for ongoing patient care. Many providers were unaware of a new diagnostic coding requirement, which had 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, many of the claims were denied as untimely, because the plan's 90-day filing window (which is 90 days from the date of service) had long expired. While providers in this situation are currently working with the health plan to find recourse, the matter has still yet to be fully resolved. The author and sponsors argue that this could have been avoided if providers were given a fair opportunity to cure before payment was recouped.

c) Existing provider dispute process. Existing law directs DMHC and CDI regulated plans to establish a fast, fair, and cost-effective dispute resolution mechanism to process and resolve both contract and non-contracted provider disputes. DMHC regulations specifically detail a process for disputes over claims and requests for reimbursement of an overpayment of a claim. DMHC's regulations require the provider to clearly identify the disputed item, the date of service and give a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for

reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect. A provider has 365 days from a plan's action (or inaction) to submit a provider dispute. The plan must acknowledge receipt of the dispute and issue a decision within 45 working days. The plan must pay any amounts owed within five working days if the dispute is resolved in the provider's favor. Despite the existence of this process, the author and sponsors of this bill argue that it does not clearly require a plan to accept and process a corrected claim when the denial or overpayment is based on a fixable defect.

3) **SUPPORT**. This bill is sponsored by the American College of Obstetricians and Gynecologists District IX (ACOG), who state that under current law health care providers may be denied payment or subjected to overpayment demands based on minor, correctable technical defects - such as coding or documentation errors - even when the underlying service was medically necessary and properly delivered. Depending on when the providers are notified of the denial, providers may be unable to correct billing errors because the original claim filing deadline has already passed. ACOG continues that these claims-filing deadlines can prevent providers from quickly remedying these defects, resulting in delayed reimbursement, administrative waste, and unnecessary disputes that ultimately disrupt patient care. ACOG argues that this bill addresses the problem by establishing a uniform right for providers to submit a corrected claim within 90 days following a plan's latest action (such as a denial or overpayment notice) if that corrected claim would resolve the issue. Furthermore, ACOG states that health care service plans would be prohibited from rejecting those corrected claims based on filing deadlines - ensuring fair payment, reducing avoidable conflicts, and promoting efficient claims processing. ACOG concludes that by giving providers a clear 90-day window to fix correctable claim defects after a denial or overpayment notice, this bill will reduce the volume of provider disputes, independent medical reviews, and litigation that state regulators must process, thereby lowering administrative workload and other costs.

4) **OPPOSED UNLESS AMENDED**. The California Association of Health Plans and Association of California Life and Health Insurance Companies are opposed to this bill unless it is amended. The opposition is concerned that this bill, as drafted, would establish a new and potentially confusing process that overlaps with California's existing claims payment and dispute resolution framework. The opposition notes that currently, health plans and insurers are required to pay, contest, or deny complete claims within specified timeframe and, if a claim is contested or denied, to provide written notice identifying the disputed portion of the claim and the basis for that action. California's provider dispute resolution process also permits providers to challenge, appeal, or seek reconsideration of denied, adjusted, contested, or overpayment claims. The opposition continues that DMHC's regulations require plans to issue a written determination within 45 working days after receiving the dispute. Similarly, state law requires CDI regulated health insurers to maintain a fast, fair, and cost-effective dispute resolution mechanism and to issue a written determination within 45 working days after receipt of a provider dispute. Given the extensive existing provider dispute resolution framework, the opposition is concerned that this bill, as drafted, will not resolve the issues raised by the sponsors but rather will create additional confusion as providers attempt to determine what standard applies in a given situation. For this reason, the opposition requests that the bill be clarified to ensure disputes related to denials and overpayments are addressed through, or integrated into, the existing provider dispute resolution process.

5) **RELATED LEGISLATION**. AB 2499 (Gipson) would require a health plan or insurer to accept electronic medical records and supporting documentation necessary to process a claim through a standard electronic submission method, as defined, and would prohibit a plan or insurer from denying, pending, or delaying a claim solely because the plan's or insurer's systems are unable to accept documentation that otherwise meets the plan's or insurer's requirements. AB 2499 is currently pending in the Senate Health Committee.

6) **PREVIOUS LEGISLATION**.

   a) AB 3275 (Soria) Chapter 763, Statutes of 2024, reduces the timeframe, from 30 or 45 working days to 30 calendar days, required for a health plan, health maintenance organization, or health insurer to pay provider claims. AB 3275 increases the interest penalty on plans and insurers that fail to meet timelines in the law.

   b) AB 1455 (Scott) Chapter 827, Statutes of 2000, establishes a dispute resolution process of claims for medical services between providers and plans as to unfair and unjust payment and billing patterns.

7) **POLICY COMMENT**. According to the sponsors, the issues that led to the conception of this bill are relatively new and were driven by the actions of a single health plan. Otherwise, issues of overpayment, and related disputes were managed relatively fast and fairly between providers and plans. The actions of this plan have led to serious financial implications for providers. An example shared by the sponsors detailed that in 2025 a physician was notified of overpayment of claims from 2 years prior due to a missing diagnostic code on her claims. Due to the 2-year lapse in time since the claim was submitted, the provider could not simply resubmit a corrected claim as it was far beyond the 90-day claim filing window for the services provided. The provider instead had to pursue a dispute with the plan. As the provider engaged in the dispute process with the plan, she had over $120,000 in payments withheld from her practice over the past year. Despite correcting the contested claims, she is still awaiting reimbursement for over $33,000 in withheld payments over a year later. While disputes regarding overpayments haven't been a glaring issue in the past nor have they occurred with any other plans besides the one in the state, there is merit to the sponsors' desire to clarify that a provider should be given a window to cure simple claim errors before payment is withheld. However, the opposition's point that this could be clarified as part of the existing dispute process instead of creating an entire new correction process is well taken as this legislature has prioritized reducing the administrative complexity of our health care systems in recent years. The author, sponsors, and opposition may wish to work with DMHC and CDI to explore whether there are pathways to clarify or establish a claim curing process within the existing provider dispute process as this bill moves forward.

REGISTERED SUPPORT / OPPOSITION:

Support

American College of Obstetricians & Gynecologists - District IX (sponsor)
California Medical Association (sponsor)
California Alliance of Child and Family Services
California Association of Medical Product Suppliers
California Chapter American College of Cardiology
California Chapter of the American College of Emergency Physicians

California Dental Association
California Hospital Association
California Optometric Association
California Orthopedic Association
California Podiatric Medical Association
California Radiological Society
California Rheumatology Alliance
California Society of Health-system Pharmacists
California Society of Pathologists
California Society of Plastic Surgeons
CPCA Advocates, Subsidiary of the California Primary Care Association
Planned Parenthood Affiliates of California

Opposition

None on file

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