Date of Hearing: August 5, 2026

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Buffy Wicks, Chair
SB 1049 (Weber Pierson) – As Amended April 6, 2026

Policy Committee: Health Vote: 15 - 0

Urgency: No State Mandated Local Program: Yes Reimbursable: No

SUMMARY:

This bill requires a health plan or health insurer (collectively, health plan) to grant a health care provider 90 days to submit a corrected claim if the health plan denies a claim or sends notice of overpayment for a claim based on a defect that can be remedied by a corrected claim.

FISCAL EFFECT:

DMHC estimates costs of approximately $271,000 MCF in fiscal year (FY) 2026-27, $281,000 in FY 2027-28, and $273,000 in FY 2028-29 and annually thereafter for workload to draft legal memoranda, assist with legal opinions and reviews, and promulgate regulations (Managed Care Fund).

The Department of Insurance anticipates no costs.

COMMENTS:

1) **Purpose.** This bill is sponsored by the American College of OB-GYNs District IX and California Medical Association. 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. SB 1049 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.** According to background information submitted by the author and sponsors, over the past year obstetrics practices throughout the state have received notices that their obstetric claims were paid incorrectly. For 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 since expired. The

matter has 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.

3) **Oppose Unless Amended.** The California Association of Health Plans (CAHP) and Association of California Life and Health Insurance Companies (ACLHIC) write that this bill would establish a new and potentially confusing process that overlaps with California's existing claims payment and dispute resolution framework. CAHP and ACLHIC write that currently, health plans and insurers are required to pay, contest, or deny complete claims within a 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. Given the existing provider dispute resolution framework, CAHP and ACLHIC are concerned that this bill 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, CAHP and ACLHIC request 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.

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