SENATE THIRD READING
SB 1049 (Weber Pierson)
As Amended August 13, 2026
Majority vote

SUMMARY

Grants a claimant no less than 90 calendar days to submit a corrected claim after a health plan or health insurer denies a claim, denies a portion of 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 claim was not submitted within another applicable claim filing deadline. Requires a dispute related to a corrected claim to be eligible for submission to the health plan or insurer's existing dispute resolution mechanism.

COMMENTS

Unfair payment patterns. The Department of Managed Health Care (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:"

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

2) 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;

3) 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;

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

5) 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,

6) 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.

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.

Existing provider dispute process. Existing law directs DMHC and California Department of Insurance (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.

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.

Arguments in 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.

Arguments in Opposition
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 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.

FISCAL COMMENTS

According to the Assembly Committee on Appropriations:

1) DMHC estimates costs of approximately $271,000 from the Managed Care Fund 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.

2) CDI anticipates no costs.

VOTES

SENATE FLOOR: 32-2-6
YES: Allen, Archuleta, Arreguín, Ashby, Becker, Blakespear, Cabaldon, Caballero, Cervantes, Cortese, Durazo, Gonzalez, Grayson, Hurtado, Laird, Limón, McGuire, McNerney, Menjivar, Ochoa Bogh, Padilla, Pérez, Reyes, Richardson, Rubio, Smallwood-Cuevas, Stern, Strickland, Umberg, Wahab, Weber Pierson, Wiener
NO: Choi, Seyarto
ABS, ABST OR NV: Alvarado-Gil, Dahle, Grove, Jones, Niello, Valladares

ASM HEALTH: 15-0-1
YES: Bonta, Sanchez, Addis, Aguiar-Curry, Ahrens, Caloza, Carrillo, Jeff Gonzalez, Mark González, Patel, Patterson, Celeste Rodriguez, Schiavo, Sharp-Collins, Stefani
ABS, ABST OR NV: Johnson

ASM APPROPRIATIONS: 11-0-4
YES: Wicks, Arambula, Calderon, Caloza, Fong, Mark González, Krell, Pacheco, Pellerin, Sharp-Collins, Solache
ABS, ABST OR NV: Hoover, Dixon, Ta, Tangipa

UPDATED

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