UNFINISHED BUSINESS

Bill No: SB 1049
Author: Weber Pierson (D), et al.
Amended: 8/13/26
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

SENATE FLOOR: 32-2, 5/19/26
AYES: 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
NOES: Choi, Seyarto
NO VOTE RECORDED: Alvarado-Gil, Dahle, Grove, Jones, Niello, Valladares

ASSEMBLY FLOOR: 73-0, 8/20/26 - See last page for vote

SUBJECT: Health care claims reimbursement

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

DIGEST: This bill provides no less than 90 calendar days for a claimant 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.

Assembly Amendments include in this bill denials of a portion of a claim and clarify that a claimant has no less than 90 calendar days to submit a corrected claim. Indicate that a dispute related to a corrected claim submitted pursuant to this bill is eligible for submission to the plan's or insurer's fast, fair, and cost-effective dispute resolution mechanism. Allow the Department of Managed Health Care, the Department of Insurance and the Department of Health Care Services to issue guidance, not subject to the Administrative Procedure Act.

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 portion thereof 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 claimant no less than 90 calendar 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 claim was not submitted within the applicable claim filing deadline other than the deadline specified in 1) directly above.

3) Requires a dispute related to a corrected claim to be eligible for submission to the plan's or insurer's fast, fair, and cost-effective dispute resolution mechanism.

4) Authorizes DMHC and California Department of Insurance (CDI) to issue guidance and amend or issue necessary regulations relating to this section, not subject to the Administrative Procedures Act. Authorizes the Department of Health Care Services to also issue necessary guidance and regulations that are consistent with guidance and regulations issued by DMHC.

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.

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

According to the Assembly Appropriations Committee, DMHC estimates costs of approximately $271,000 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 (Managed Care Fund).

CDI anticipates no costs.

SUPPORT: (Verified 8/20/26)

American College of Obstetricians & Gynecologists – District IX (co-source)
California Medical Association (co-source)
California Academy of Child and Adolescent Psychiatry
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 Physical Therapy Association
California Podiatric Medical Association
California Primary Care 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
Los Angeles LGBT Center
Physician Association of California
Planned Parenthood Affiliates of California

OPPOSITION: (Verified 8/20/26)

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: The California Association of Health Plans and the Association of California Life and Health Insurance Companies believe given the extensive existing provider dispute resolution framework this bill will not resolve the issues raised by the sponsors but rather create additional confusion as providers attempt to determine what standard applies in a given situation.

ASSEMBLY FLOOR: 73-0 8/20/26

AYES: Addis, Aguiar-Curry, Ahrens, Alanis, Alvarez, Arambula, Ávila Farías, Bains, Bauer-Kahan, Bennett, Berman, Boerner, Bonta, Bryan, Calderon, Caloza, Carrillo, Castillo, Connolly, Davies, DeMaio, Elhawary, Fong, Gabriel, Garcia, Gipson, Jeff Gonzalez, Mark González, Haney, Harabedian, Hart, Hoover, Irwin, Jackson, Johnson, Kalra, Krell, Lackey, Lee, Lowenthal, McKinnor, Muratsuchi, Nguyen, Ortega, Pacheco, Papan, Patel, Patterson, Pellerin, Petrie-Norris, Quirk-Silva, Ramos, Ransom, Celeste Rodriguez, Michelle Rodriguez, Rogers, Blanca Rubio, Sanchez, Schiavo, Schultz, Sharp-Collins, Solache, Soria, Stefani, Ta, Tangipa, Valencia, Wallis, Ward, Wicks, Wilson, Zbur, Rivas
NO VOTE RECORDED: Chen, Dixon, Ellis, Flora, Hadwick, Macedo

Prepared by: Teri Boughton / HEALTH / (916) 651-4111
8/20/26 13:54:01

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