

AMENDED IN SENATE JUNE 27, 2019

AMENDED IN ASSEMBLY MAY 16, 2019

AMENDED IN ASSEMBLY APRIL 29, 2019

AMENDED IN ASSEMBLY APRIL 22, 2019

CALIFORNIA LEGISLATURE—2019–20 REGULAR SESSION

ASSEMBLY BILL

No. 1611

Introduced by Assembly Member Chiu

(Principal coauthor: Senator Wiener)

(Coauthor: Assembly Member Ting)

February 22, 2019

An act to amend Section 1317.2a of, and to add Sections 1317.11, 1317.12, 1371.6, 1371.7, and 1385.035 to, the Health and Safety Code, and to add Sections 10112.91, 10112.92, and 10181.35 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1611, as amended, Chiu. Emergency hospital services: costs.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service plans and makes a willful violation of the act a crime. Existing law requires the Department of Insurance to regulate health insurers. Existing law requires a health care service plan or health insurer offering a contract or policy to provide coverage for emergency services. Existing law prohibits a hospital from transferring a person needing emergency services and care to another hospital for any nonmedical reason unless prescribed conditions are met and makes a willful violation of this requirement a crime.

This bill would require a health care service plan contract or insurance policy issued, amended, or renewed on or after January 1, 2020, to provide that if an enrollee or insured receives covered *emergency* services from a noncontracting hospital, except as specified, the enrollee or insured is prohibited from paying more than the same cost sharing that the enrollee or insured would pay for the same covered services received from a contracting hospital. The bill would require a health care service plan or insurer to pay a noncontracting hospital for emergency services rendered to an enrollee or insured pursuant to a specified formula, would require a noncontracting hospital to bill, collect, and make refunds in a specified manner, and would provide a dispute resolution procedure if any party is dissatisfied with payment. The bill would require health care service plans and insurers to document cost savings pursuant to these provisions. By expanding the duties of health care services plans and hospitals, this bill would expand existing crimes, thereby imposing a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Section 1317.11 is added to the Health and Safety
2 Code, to read:
3 1317.11. (a) (1) A hospital that has a legal obligation, whether
4 imposed by statute or by contract, to the extent of that contractual
5 obligation, to any third-party payor, including, but not limited to,
6 a health maintenance organization, health care service plan,
7 nonprofit hospital service plan, insurer, or preferred hospital
8 organization, a county, or an employer to provide emergency care,
9 as defined in Section 1317.1, ~~or poststabilization care, as defined~~
10 ~~in Section 1371.4~~, for a patient, shall not charge more than the
11 reasonable and customary value of the hospital services, as defined
12 in paragraph (2) or the average contracted rate ~~on a fee-for-service~~
13 ~~basis~~ for the same or similar hospital services in the general
14 geographic region in which the services were rendered. For the

1 purposes of this section, “average contracted rate” means the
2 average of the contracted commercial rates paid by the health plan
3 or delegated entity for the same or similar *emergency* services in
4 the geographic region.

5 (2) For purposes of this section, “reasonable and customary
6 value of the hospital services” means the payment of the reasonable
7 and customary value for the health care services rendered based
8 upon statistically credible information that is updated at least
9 annually and takes into consideration all of the following:

10 (A) The provider’s training, qualifications, and length of time
11 in practice.

12 (B) The nature of the services provided.

13 (C) The fees usually charged by or paid to the provider,
14 including rates paid by both commercial and governmental payers.

15 (D) Prevailing provider rates charged and paid by both
16 commercial and governmental payers in the general geographic
17 area in which the services were rendered.

18 (E) Other relevant aspects of the economics of the medical
19 provider’s practice.

20 (F) Any unusual circumstances in the case.

21 (b) Notwithstanding this section, the liability of a third-party
22 payor that is licensed by the Insurance Commissioner or the
23 Director of the Department of Managed Health Care and has a
24 contractual obligation to provide or indemnify emergency medical
25 services under a contract that covers a subscriber or an enrollee
26 shall be determined in accordance with the terms of that contract
27 and shall remain under the sole jurisdiction of that licensing
28 agency.

29 (c) A third-party payor shall not be liable for payment for
30 emergency services if the third-party payor reasonably determines
31 that the emergency services and care were never performed,
32 provided that a third-party payor may deny reimbursement to a
33 hospital for a medical screening examination in cases in which the
34 plan enrollee did not require emergency services and care and the
35 enrollee reasonably should have known that an emergency did not
36 exist.

37 (d) If dissatisfied, either the hospital or the third-party payor
38 may pursue any right, remedy, or penalty established under any
39 other applicable law.

(e) *This section does not apply to a Medi-Cal managed health care services plan or any other entity that enters into a contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) of, Chapter 8 (commencing with Section 14200) of, and Chapter 8.75 (commencing with Section 14591) of, Part 3 of Division 9 of the Welfare and Institutions Code.*

(e)

(f) This section does not apply to services provided by a licensed physician and surgeon, nurse practitioner, or physician assistant.

SEC. 2. Section 1317.12 is added to the Health and Safety Code, to read:

1317.12. (a) (1) A hospital that provides care subject to Section 1317.1 or 1317.2 shall provide that if a patient receives covered services consistent with Section 1317.1 or 1317.2, ~~or poststabilization care, as defined in Section 1371.4,~~ the patient shall pay no more than the same cost sharing that the patient would pay for the same covered *emergency* services received from a contracting hospital. This amount shall be referred to as the “in-network cost-sharing amount.”

(2) An enrollee shall not owe a hospital that provides emergency ~~or other~~ services consistent with Section 1317.1 or ~~1317.2, or poststabilization care, as defined in Section 1371.4,~~ 1317.2 more than the in-network cost-sharing amount for services subject to this section. The hospital shall be provided information on the amount of the in-network cost sharing by the third-party payor.

(3) A hospital shall not bill or collect any amount from the patient for services subject to this section except for the in-network cost-sharing amount. Any communication from the noncontracting hospital *regarding services covered under this section* to the patient shall include a notice in 12-point bold type stating that the communication is not a bill and informing the patient that the patient shall not pay until the patient is informed by the patient’s third-party payor of any applicable cost sharing.

(4) (A) If the hospital has received more than the in-network cost-sharing amount from the patient for services subject to this section, the noncontracting hospital shall refund any overpayment to the patient within 30 calendar days after receiving payment from the patient.

1 (B) If the hospital does not refund any overpayment to the
2 patient within 30 calendar days after being informed of the patient's
3 in-network cost-sharing amount, interest shall accrue at the rate
4 of 15 percent per annum beginning with the date payment was
5 received from the enrollee.

6 (C) A hospital shall automatically include in the refund to the
7 patient all interest that has accrued pursuant to this section without
8 requiring the enrollee to submit a request for the interest amount.

9 (b) If a patient does not have a third-party payor and a hospital
10 determines, consistent with Article 1 (commencing with Section
11 127400) of Chapter 2.5 of Part 2 of Division 107, that a patient is
12 participating in the charity care or discount payment policy
13 provisions of that article, then this section shall not apply to that
14 patient. If a patient does not have a third-party payor and has not
15 yet begun to participate in either the charity care or discount
16 payment policy provisions of Article 1 (commencing with Section
17 127400) of Chapter 2.5 of Part 2 of Division 107, then the hospital
18 shall, consistent with subdivision (b) of Section 127420, provide
19 information on the hospital's charity care and discount payment
20 policies, as well as information on how to apply for Medi-Cal and
21 any other applicable coverage.

22 (c) (1) A hospital may advance to collections only the
23 in-network cost-sharing amount, ~~as determined by~~ *upon receipt*
24 *of information from* the third-party payor pursuant to subdivision
25 (a), that the enrollee has failed to pay.

26 (2) The hospital, or any entity acting on its behalf, including
27 any assignee of the debt, shall not report adverse information to a
28 consumer credit reporting agency or commence civil action against
29 the enrollee for a minimum of 150 days after the initial billing
30 regarding amounts owed by the enrollee under subdivision (a) or
31 (b).

32 (3) With respect to a patient subject to this section, the
33 noncontracting hospital, or any entity acting on its behalf, including
34 any assignee of the debt, shall not use wage garnishments or liens
35 on primary residences as a means of collecting unpaid bills under
36 this section.

37 (d) For purposes of this section, the following definitions shall
38 apply:

1 (1) “Contracting hospital” means a hospital that is contracted
2 with the patient’s third-party payor to provide services under the
3 patient’s contract.

4 (2) “Cost sharing” includes any copayment, coinsurance, or
5 deductible, or any other form of cost sharing paid by the enrollee
6 other than premium or share of premium.

7 (3) “In-network cost-sharing amount” means an amount no more
8 than the same cost sharing the enrollee would pay for the same
9 covered service received from a contracting hospital.

10 (4) “Third-party payor” means any third-party payor, including,
11 but not limited to, a health maintenance organization, health care
12 service plan, nonprofit hospital service plan, insurer, or preferred
13 hospital organization, a county, or an employer that by statute or
14 contract is required to cover emergency care.

15 (e) This section shall not be construed to require a third-party
16 payor to cover services not required by law or by the terms and
17 conditions of the third-party contract.

18 (f) This section shall not be construed to exempt a plan or
19 hospital from the requirements under Section 1371.4 or 1373.96,
20 nor abrogate the holding in *Prospect Medical Group, Inc. v.*
21 *Northridge Emergency Medical Group* (2009) 45 Cal.4th 497.

22 (g) This section shall not apply to a Medi-Cal managed health
23 care service plan or any other entity that enters into a contract with
24 the State Department of Health Care Services pursuant to Chapter
25 7 (commencing with Section 14000), Chapter 8 (commencing with
26 Section 14200), and Chapter 8.75 (commencing with Section
27 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.

28 (h) This section does not apply to services provided by a licensed
29 physician and surgeon, nurse practitioner, or physician assistant.

30 SEC. 3. Section 1317.2a of the Health and Safety Code is
31 amended to read:

32 1317.2a. (a) A hospital that has a legal obligation, whether
33 imposed by statute or by contract, to the extent of that contractual
34 obligation, to any third-party payor, including, but not limited to,
35 a health maintenance organization, health care service plan,
36 nonprofit hospital service plan, insurer, or preferred provider
37 organization, a county, or an employer to provide care for a patient
38 under the circumstances specified in Section 1317.2 shall receive
39 that patient to the extent required by the applicable statute or by
40 the terms of the contract, or, when the hospital is unable to accept

1 a patient for whom it has a legal obligation to provide care whose
2 transfer will not create a medical hazard as specified in Section
3 1317.2, it shall make appropriate arrangements for the patient's
4 care.

5 (b) A county hospital shall accept a patient whose transfer will
6 not create a medical hazard as specified in Section 1317.2 and who
7 is determined by the county to be eligible to receive health care
8 services required under Part 5 (commencing with Section 17000)
9 of Division 9 of the Welfare and Institutions Code, unless the
10 hospital does not have appropriate bed capacity, medical personnel,
11 or equipment required to provide care to the patient in accordance
12 with accepted medical practice. When a county hospital is unable
13 to accept a patient whose transfer will not create a medical hazard
14 as specified in Section 1317.2, it shall make appropriate
15 arrangements for the patient's care. The obligation to make
16 appropriate arrangements as set forth in this subdivision does not
17 mandate a level of service or payment, modify the county's
18 obligations under Part 5 (commencing with Section 17000) of
19 Division 9 of the Welfare and Institutions Code, create a cause of
20 action, or limit a county's flexibility to manage county health
21 systems within available resources. However, the county's
22 flexibility shall not diminish a county's responsibilities under Part
23 5 (commencing with Section 17000) of Division 9 of the Welfare
24 and Institutions Code or the requirements contained in Chapter
25 2.5 (commencing with Section 1440).

26 (c) The receiving hospital shall provide personnel and
27 equipment reasonably required in the exercise of good medical
28 practice for the care of the transferred patient.

29 (d) (1) A third-party payor, including, but not limited to, a
30 health maintenance organization, health care service plan, nonprofit
31 hospital service plan, insurer, or preferred provider organization,
32 or employer that has a statutory or contractual obligation to provide
33 or indemnify emergency medical services on behalf of a patient
34 shall be liable, to the extent of the contractual obligation to the
35 patient, for the reasonable charges of the transferring hospital and
36 the treating physicians for the emergency services provided
37 pursuant to this article, except that the patient shall be responsible
38 for uncovered services, or any deductible or copayment obligation.

39 (2) Notwithstanding this section, the liability of a third-party
40 payor that has contracted with health care providers for the

1 provision of these emergency services shall be set by the terms of
2 that contract.

3 (3) Notwithstanding this section, the liability of a third-party
4 payor that is licensed by the Insurance Commissioner or the
5 Director of the Department of Managed Health Care and has a
6 contractual obligation to provide or indemnify emergency medical
7 services under a contract that covers a subscriber or an enrollee
8 shall be determined in accordance with the terms of that contract
9 and shall remain under the sole jurisdiction of that licensing
10 agency.

11 (4) (A) Reasonable charges for hospital services provided
12 consistent with this section shall not exceed the reasonable and
13 customary value of the hospital services, as defined in subparagraph
14 (B), or the average contracted rate ~~on a fee-for-service basis~~ for
15 the same or similar services in the general geographic region in
16 which the services were rendered. For the purposes of this section,
17 “average contracted rate” means the average of the contracted
18 commercial rates paid by the health plan or delegated entity for
19 the same or similar services in the geographic region. If dissatisfied
20 with reasonable charges as defined in this section, either the
21 hospital or the third-party payor may pursue any right, remedy, or
22 penalty established under any other applicable law.

23 (B) For purposes of this section, “reasonable and customary
24 value of the hospital services” means the payment of the reasonable
25 and customary value for the health care services rendered based
26 upon statistically credible information that is updated at least
27 annually and takes into consideration all of the following:

28 (i) The provider’s training, qualifications, and length of time in
29 practice.

30 (ii) The nature of the services provided.

31 (iii) The fees usually charged by or paid to the provider,
32 including rates paid by both commercial and governmental payers.

33 (iv) Prevailing provider rates charged and paid by both
34 commercial and governmental payers in the general geographic
35 area in which the services were rendered.

36 (v) Other relevant aspects of the economics of the medical
37 provider’s practice.

38 (vi) Any unusual circumstances in the case.

1 (C) This paragraph does not apply to services provided by a
2 licensed physician and surgeon, nurse practitioner, or physician
3 assistant.

4 (e) A hospital that has a legal obligation to provide care for a
5 patient as specified by subdivision (a) of Section 1317.2a to the
6 extent of its legal obligation, imposed by statute or by contract to
7 the extent of that contractual obligation, which does not accept
8 transfers of, or make other appropriate arrangements for, medically
9 stable patients in violation of this article or regulations adopted
10 pursuant thereto shall be liable for the reasonable charges of the
11 transferring hospital and treating physicians for providing services
12 and care that should have been provided by the receiving hospital.

13 (f) Subdivisions (d) and (e) do not apply to county obligations
14 under Section 17000 of the Welfare and Institutions Code.

15 (g) This section shall not be interpreted to require a hospital to
16 make arrangements for the care of a patient for whom the hospital
17 does not have a legal obligation to provide care.

18 SEC. 4. Section 1371.6 is added to the Health and Safety Code,
19 to read:

20 1371.6. (a) (1) A health care service plan contract issued,
21 amended, or renewed on or after January 1, 2020, shall provide
22 that if an enrollee receives covered *emergency* services consistent
23 with Section 1371.4 ~~or 1371.5~~ from a noncontracting hospital, the
24 enrollee shall pay no more than the same cost sharing that the
25 enrollee would pay for the same covered services received from
26 a contracting hospital. This amount shall be referred to as the
27 “in-network cost-sharing amount.”

28 (2) An enrollee shall not owe a noncontracting hospital that
29 provides emergency ~~or other~~ services consistent with Section
30 1371.4 ~~or 1371.5~~ more than the in-network cost-sharing amount
31 for services subject to this section. At the time of payment by the
32 plan to the noncontracting hospital, the plan shall inform the
33 enrollee and the noncontracting hospital of the in-network
34 cost-sharing amount owed by the enrollee.

35 (3) A noncontracting hospital shall not bill or collect any amount
36 from the enrollee for services subject to this section except for the
37 in-network cost-sharing amount. Any communication from the
38 noncontracting hospital to the enrollee prior to the receipt of
39 information about the in-network cost-sharing amount pursuant
40 to paragraph (2) shall include a notice in 12-point bold type stating

1 that the communication is not a bill and informing the enrollee
2 that the enrollee shall not pay until the enrollee is informed by the
3 enrollee's health care service plan of any applicable cost sharing.

4 (4) (A) If the noncontracting hospital has received more than
5 the in-network cost-sharing amount from the enrollee for services
6 subject to this section, the noncontracting hospital shall refund any
7 overpayment to the enrollee within 30 calendar days after receiving
8 payment from the enrollee.

9 (B) If the noncontracting hospital does not refund any
10 overpayment to the enrollee within 30 calendar days after being
11 informed of the enrollee's in-network cost-sharing amount, interest
12 shall accrue at the rate of 15 percent per annum beginning with
13 the date payment was received from the enrollee.

14 (C) A noncontracting hospital shall automatically include in the
15 refund to the enrollee all interest that has accrued pursuant to this
16 section without requiring the enrollee to submit a request for the
17 interest amount.

18 (b) The following shall apply:

19 (1) Any cost sharing paid by the enrollee for the services subject
20 to this section shall count toward the limit on annual out-of-pocket
21 expenses established under Section 1367.006.

22 (2) Cost sharing arising from services subject to this section
23 shall be counted toward any deductible in the same manner as cost
24 sharing would be attributed to a contracting hospital.

25 (3) The cost sharing paid by the enrollee pursuant to this section
26 shall satisfy the enrollee's obligation to pay cost sharing for the
27 health service and shall constitute "applicable cost sharing owed
28 by the enrollee."

29 (c) (1) A noncontracting hospital may advance to collections
30 only the in-network cost-sharing amount, as determined by the
31 plan pursuant to subdivision (a) that the enrollee has failed to pay.

32 (2) The noncontracting hospital, or any entity acting on its
33 behalf, including any assignee of the debt, shall not report adverse
34 information to a consumer credit reporting agency or commence
35 civil action against the enrollee for a minimum of 150 days after
36 the initial billing regarding amounts owed by the enrollee under
37 subdivision (a) or (b).

38 (3) With respect to an enrollee, the noncontracting hospital, or
39 any entity acting on its behalf, including any assignee of the debt,

1 shall not use wage garnishments or liens on primary residences as
2 a means of collecting unpaid bills under this section.

3 (d) For purposes of this section, the following definitions shall
4 apply:

5 (1) “Contracting hospital” means a hospital that is contracted
6 with the enrollee’s health care service plan to provide services
7 under the enrollee’s plan contract.

8 (2) “Cost sharing” includes any copayment, coinsurance, or
9 deductible, or any other form of cost sharing paid by the enrollee
10 other than premium or share of premium.

11 (3) “In-network cost-sharing amount” means an amount no more
12 than the same cost sharing the enrollee would pay for the same
13 covered service received from a contracting hospital. The
14 in-network cost-sharing amount with respect to an enrollee with
15 coinsurance shall be based on the amount paid by the plan pursuant
16 to paragraph (1) of subdivision (a) of Section 1371.31.

17 (e) This section shall not be construed to require a health care
18 service plan to cover services not required by law or by the terms
19 and conditions of the health care service plan contract.

20 (f) This section shall not be construed to exempt a plan, hospital,
21 any other individual or any other entity from the requirements
22 under Section 1371.4 or 1373.96, nor abrogate the holding in
23 Prospect Medical Group, Inc. v. Northridge Emergency Medical
24 Group (2009) 45 Cal.4th 497.

25 (g) If a health care service plan delegates payment functions to
26 a contracted entity, including, but not limited to, a medical group
27 or independent practice association, the delegated entity shall
28 comply with this section.

29 (h) This section shall not apply to a Medi-Cal managed health
30 care service plan or any other entity that enters into a contract with
31 the State Department of Health Care Services pursuant to Chapter
32 7 (commencing with Section 14000), Chapter 8 (commencing with
33 Section 14200), and Chapter 8.75 (commencing with Section
34 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.

35 (i) This section does not apply to services provided by a licensed
36 physician and surgeon, nurse practitioner, or physician assistant.

37 SEC. 5. Section 1371.7 is added to the Health and Safety Code,
38 to read:

39 1371.7. A health care service plan contract issued, amended,
40 or renewed on or after January 1, 2020, shall provide that:

(a) (1) A noncontracting health facility subject to Section 1371.6 shall be paid the reasonable and customary value of the hospital services, as defined in paragraph (3), or the average contracted rate ~~on a fee-for-service basis~~ for the same or similar services in the general geographic region in which the services were rendered. For the purposes of this section, “average contracted rate” means the average of the contracted commercial rates paid by the health plan or delegated entity for the same or similar services in the geographic region.

(2) To determine the “average contracted rate,” the health care service plan shall use the standardized methodology pursuant to paragraph (3) of subdivision (a) of Section 1371.31.

(3) For purposes of this section, “reasonable and customary value of the hospital services” means the payment of the reasonable and customary value for the health care services rendered based upon statistically credible information that is updated at least annually and takes into consideration all of the following:

(A) The provider’s training, qualifications, and length of time in practice.

(B) The nature of the services provided.

(C) The fees usually charged by or paid to the provider, including rates paid by both commercial and governmental payers.

(D) Prevailing provider rates charged and paid by both commercial and governmental payers in the general geographic area in which the services were rendered.

(E) Other relevant aspects of the economics of the medical provider’s practice.

(F) Any unusual circumstances in the case.

(b) (1) A noncontracting health facility providing emergency services subject to Section 1371.4 may use the independent dispute resolution process established under Section 1371.30. If the noncontracting health facility participates in the independent dispute resolution process, the health care service plan shall also participate.

(2) The decision obtained through the department’s independent dispute resolution process shall be binding on both parties. The plan shall implement the decision obtained through the independent dispute resolution process.

1 (c) If dissatisfied, either the health plan or the hospital may
2 pursue any right, remedy, or penalty established under any other
3 applicable law.

4 (d) This section does not apply to services provided by a licensed
5 physician and surgeon, nurse practitioner, or physician assistant.

6 SEC. 6. Section 1385.035 is added to the Health and Safety
7 Code, to read:

8 1385.035. (a) For a plan contract subject to Section 1385.03,
9 the plan shall file a separate schedule documenting the cost savings
10 associated with Section 1371.7 and the impact on rates.

11 (b) For a plan contract subject to Section 1385.04, the plan shall
12 file a separate schedule documenting cost savings associated with
13 Section 1371.7 and the impact on rates.

14 SEC. 7. Section 10112.91 is added to the Insurance Code, to
15 read:

16 10112.91. (a) (1) A health insurance policy issued, amended,
17 or renewed on or after January 1, 2020, shall provide that if an
18 insured receives covered *emergency* services consistent with
19 Section 1371.4 ~~or 1371.5~~ of the Health and Safety Code from a
20 noncontracting hospital, the insured shall pay no more than the
21 same cost sharing that the insured would pay for the same covered
22 services received from a contracting hospital. This amount shall
23 be referred to as the “in-network cost-sharing amount.”

24 (2) An insured shall not owe a noncontracting hospital that
25 provides emergency ~~or other~~ services consistent with Section
26 1371.4 ~~or 1371.5~~ of the Health and Safety Code more than the
27 in-network cost-sharing amount for services subject to this section.
28 At the time of payment by the insurer to the noncontracting
29 hospital, the insurer shall inform the insured and the noncontracting
30 hospital of the in-network cost-sharing amount owed by the
31 insured.

32 (3) A noncontracting hospital shall not bill or collect any amount
33 from the insured for services subject to this section except for the
34 in-network cost-sharing amount. Any communication from the
35 noncontracting hospital to the insured prior to the receipt of
36 information about the in-network cost-sharing amount pursuant
37 to paragraph (2) shall include a notice in 12-point bold type stating
38 that the communication is not a bill and informing the insured that
39 the insured shall not pay until the insured is informed by the
40 insured’s health insurance policy of any applicable cost sharing.

1 (4) (A) If the noncontracting hospital has received more than
2 the in-network cost-sharing amount from the insured for services
3 subject to this section, the noncontracting hospital shall refund any
4 overpayment to the insured within 30 calendar days after receiving
5 payment from the insured.

6 (B) If the noncontracting hospital does not refund any
7 overpayment to the insured within 30 calendar days after being
8 informed of the insured's in-network cost-sharing amount, interest
9 shall accrue at the rate of 15 percent per annum beginning with
10 the date payment was received from the insured.

11 (C) A noncontracting hospital shall automatically include in the
12 refund to the insured all interest that has accrued pursuant to this
13 section without requiring the insured to submit a request for the
14 interest amount.

15 (b) The following shall apply:

16 (1) Any cost sharing paid by the insured for the services subject
17 to this section shall count toward the limit on annual out-of-pocket
18 expenses established under Section 10112.28.

19 (2) Cost sharing arising from services subject to this section
20 shall be counted toward any deductible in the same manner as cost
21 sharing would be attributed to a contracting hospital.

22 (3) The cost sharing paid by the insured pursuant to this section
23 shall satisfy the insured's obligation to pay cost sharing for the
24 health service and shall constitute "applicable cost sharing owed
25 by the insured."

26 (c) (1) A noncontracting hospital may advance to collections
27 only the in-network cost-sharing amount, as determined by the
28 plan pursuant to subdivision (a) that the insured has failed to pay.

29 (2) The noncontracting hospital, or any entity acting on its
30 behalf, including any assignee of the debt, shall not report adverse
31 information to a consumer credit reporting agency or commence
32 civil action against the insured for a minimum of 150 days after
33 the initial billing regarding amounts owed by the insured under
34 subdivision (a) or (b).

35 (3) With respect to an insured, the noncontracting hospital, or
36 any entity acting on its behalf, including any assignee of the debt,
37 shall not use wage garnishments or liens on primary residences as
38 a means of collecting unpaid bills under this section.

39 (d) For purposes of this section, the following definitions shall
40 apply:

1 (1) “Contracting hospital” means a hospital that is contracted
2 with the insured’s health insurance policy to provide services under
3 the insured’s plan contract.

4 (2) “Cost sharing” includes any copayment, coinsurance, or
5 deductible, or any other form of cost sharing paid by the insured
6 other than premium or share of premium.

7 (3) “In-network cost-sharing amount” means an amount no more
8 than the same cost sharing the insured would pay for the same
9 covered service received from a contracting hospital. The
10 in-network cost-sharing amount with respect to an insured with
11 coinsurance shall be based on the amount paid by the plan pursuant
12 to paragraph (1) of subdivision (a) of Section 10112.82.

13 (e) This section shall not be construed to require a health
14 insurance policy to cover services not required by law or by the
15 terms and conditions of the health insurance policy contract.

16 (f) This section shall not be construed to exempt a health insurer,
17 hospital, any other individual, or any other entity from the
18 requirements under Section 1371.4 or 1373.96 of the Health and
19 Safety Code.

20 (g) If a health insurance policy delegates payment functions to
21 a contracted entity, including, but not limited to, a medical group
22 or independent practice association, the delegated entity shall
23 comply with this section.

24 (h) This section does not apply to services provided by a licensed
25 physician and surgeon, nurse practitioner, or physician assistant.

26 SEC. 8. Section 10112.92 is added to the Insurance Code, to
27 read:

28 10112.92. A health insurance policy issued, amended, or
29 renewed on or after January 1, 2020, shall provide that:

30 (a) (1) A noncontracting health facility subject to Section
31 10112.91 shall be paid the reasonable and customary value of the
32 hospital services, as defined in paragraph (3), or the average
33 contracted rate ~~on a fee-for-service basis~~ for the same or similar
34 services in the general geographic region in which the services
35 were rendered. For the purposes of this section, “average contracted
36 rate” means the average of the contracted commercial rates paid
37 by the insurer or delegated entity for the same or similar services
38 in the geographic region.

(2) To determine the “average contracted rate,” the health insurer shall use the standardized methodology pursuant to paragraph (3) of subdivision (a) of Section 10112.82.

(3) For purposes of this section, “reasonable and customary value of the hospital services” means the payment of the reasonable and customary value for the health care services rendered based upon statistically credible information that is updated at least annually and takes into consideration all of the following:

(A) The provider’s training, qualifications, and length of time in practice.

(B) The nature of the services provided.

(C) The fees usually charged by or paid to the provider, including rates paid by both commercial and governmental payers.

(D) Prevailing provider rates charged and paid by both commercial and governmental payers in the general geographic area in which the services were rendered.

(E) Other relevant aspects of the economics of the medical provider’s practice.

(F) Any unusual circumstances in the case.

(b) (1) A noncontracting health facility providing emergency services subject to Section 1371.4 of the Health and Safety Code may use the independent dispute resolution process established under Section 10112.81. If the noncontracting health facility participates in the independent dispute resolution process, the insurer shall also participate.

(2) The decision obtained through the department’s independent dispute resolution process shall be binding on both parties. The insurer shall implement the decision obtained through the independent dispute resolution process.

(c) If dissatisfied, either the hospital or a third-party payor may pursue any right, remedy, or penalty established under any other applicable law.

(d) This section does not apply to services provided by a licensed physician and surgeon, nurse practitioner, or physician assistant.

SEC. 9. Section 10181.35 is added to the Insurance Code, to read:

10181.35. (a) For a policy subject to Section 10181.3, the insurer shall file a separate schedule documenting the cost savings associated with Section 10112.91 and the impact on rates.

1 (b) For a policy contract subject to Section 10181.4, the insurer
2 shall file a separate schedule documenting cost savings associated
3 with Section 10112.92 and the impact on rates.

4 SEC. 10. No reimbursement is required by this act pursuant to
5 Section 6 of Article XIII B of the California Constitution because
6 the only costs that may be incurred by a local agency or school
7 district will be incurred because this act creates a new crime or
8 infraction, eliminates a crime or infraction, or changes the penalty
9 for a crime or infraction, within the meaning of Section 17556 of
10 the Government Code, or changes the definition of a crime within
11 the meaning of Section 6 of Article XIII B of the California
12 Constitution.