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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:

SECTION 1. Section 1317.11 is added to the Health and Safety Code, to read:

1317.11. (a) (1) A hospital that has a legal obligation, whether imposed by statute or by contract, to the extent of that contractual obligation, to any third-party payor, including, but not limited to, a health maintenance organization, health care service plan, nonprofit hospital service plan, insurer, or preferred hospital organization, a county, or an employer to provide emergency care, as defined in Section 1317.1, ~~or poststabilization care, as defined in Section 1371.4,~~ for a patient, shall not charge more than the reasonable and customary value of the hospital services, as defined in paragraph (2) or the average contracted rate ~~on a fee-for-service basis~~ for the same or similar hospital 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 *emergency* services in the geographic region.

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

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

(d) If dissatisfied, either the hospital or the third-party payor may pursue any right, remedy, or penalty established under any 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.

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

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

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

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

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

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

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

(1) "Contracting hospital" means a hospital that is contracted with the patient's third-party payor to provide services under the patient's contract.

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

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

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

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

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

(g) This section shall not apply to a Medi-Cal managed health care service 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), Chapter 8 (commencing with Section 14200), and Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.

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

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

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

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

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

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

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

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

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

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

(4) (A) Reasonable charges for hospital services provided consistent with this section shall not exceed the reasonable and customary value of the hospital services, as defined in subparagraph (B), 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. If dissatisfied with reasonable charges as defined in this section, either the hospital or the third-party payor may pursue any right, remedy, or penalty established under any other applicable law.

(B) 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:

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

(ii) The nature of the services provided.

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

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

(v) Other relevant aspects of the economics of the medical provider's practice.

(vi) Any unusual circumstances in the case.

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

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

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

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

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

1371.6. (a) (1) A health care service plan contract issued, amended, or renewed on or after January 1, 2020, shall provide that if an enrollee receives covered *emergency* services consistent with Section 1371.4 ~~or 1371.5~~ from a noncontracting hospital, the enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same covered 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 noncontracting hospital that provides emergency ~~or other~~ services consistent with Section 1371.4 ~~or 1371.5~~ more than the in-network cost-sharing amount for services subject to this section. At the time of payment by the plan to the noncontracting hospital, the plan shall inform the enrollee and the noncontracting hospital of the in-network cost-sharing amount owed by the enrollee.

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

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

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

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

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

(b) The following shall apply:

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

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

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

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

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

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

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

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

(1) "Contracting hospital" means a hospital that is contracted with the enrollee's health care service plan to provide services under the enrollee's plan contract.

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

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

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

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

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

(h) This section shall not apply to a Medi-Cal managed health care service 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), Chapter 8 (commencing with Section 14200), and Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.

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

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

1371.7. A health care service plan contract issued, amended, 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.

(c) If dissatisfied, either the health plan or the hospital 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. 6. Section 1385.035 is added to the Health and Safety Code, to read:

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

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

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

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

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

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

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

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

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

(b) The following shall apply:

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

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

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

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

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

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

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

(1) "Contracting hospital" means a hospital that is contracted with the insured's health insurance policy to provide services under the insured's plan contract.

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

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

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

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

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

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

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

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

(a) (1) A noncontracting health facility subject to Section 10112.91 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 insurer or delegated entity for the same or similar services 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.

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

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

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